

IN THE UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF ILLINOIS  
EASTERN DIVISION

JOVAN D. DANIELS, )  
Plaintiff, ) Civil Action  
vs. ) No. 1:16-cv-00014  
WEXFORD HEALTH SOURCES, INC., )  
et al., )  
Defendants. )

The 30(b)(6) deposition of WEXFORD  
HEALTH SOURCES, INC., by ARTHUR FUNK, M.D., called  
for examination, taken pursuant to the Federal  
Rules of Civil Procedure of the United States  
District Courts pertaining to the taking of  
depositions, taken before KRISTIN C. BRAJKOVICH, a  
Certified Shorthand Reporter, CSR. No. 84-3810, of  
said state, via Zoom, on the 18th day of March,  
A.D. 2022, at 10:00 a.m.

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1 PRESENT:  
2  
3 FOLEY & LARDNER LLP,  
4 (321 North Clark Street, Suite 3000,  
5 Chicago, Illinois 60654-5313,  
6 1-312-832-4500), by:  
7 MS. JASMINE REED,  
8 jreed@foley.com, and  
9 MS. ELVIA R. ANGUIANO,  
10 eanguiano@foley.com,  
11 appeared via zoom on behalf of  
12 Plaintiff;  
13  
14 CASSIDAY SCHADE LLP,  
15 (222 West Adams Street, Suite 2900,  
16 Chicago, Illinois 60606,  
17 1-312-641-3100), by:  
18 MR. JOSEPH J. LOMBARDO,  
19 jlombardo@cassiday.com,  
20 appeared via Zoom on behalf of  
21 Defendants.  
22  
23 REPORTED BY: KRISTIN C. BRAJKOVICH,  
24 CSR No. 84-3810.

10:02 1 MS. REED: Thank you. We are here for the  
10:02 2 30(b)(6) deposition of -- give me one second --  
10:02 3 Wexford.  
4 ARTHUR FUNK, M.D.,  
5 called as a witness herein, having been first duly  
6 sworn, was examined and testified as follows:  
7 EXAMINATION  
8 BY MS. REED:  
10:02 9 Q. And, Dr. Funk, you have been designated  
10:03 10 by Wexford to be their corporate rep today; is that  
10:03 11 correct?  
10:03 12 A. Yes.  
10:03 13 Q. And have you been deposed before?  
10:03 14 A. Yes.  
10:03 15 Q. Okay. Well, I'm just going to go over  
10:03 16 three quick ground rules just to make sure that we  
10:03 17 are on the same page, but I'm not going to do my  
10:03 18 whole spiel for you. Is that okay?  
10:03 19 A. That is fine with me.  
10:03 20 Q. So the first one and most important one  
10:03 21 is, remember the court reporter, the lovely court  
10:03 22 reporter is taking down everything we say, so we  
10:03 23 just want to make sure that we don't talk over each  
10:03 24 other so it makes it easier for her. Are you okay

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10:03 1 with that?

10:03 2 A. That's fine.

10:03 3 Q. Second one, make sure you understand my

10:03 4 question. I'm back in the Midwest now. But I used

10:03 5 to practice in Denver and California, so I would

10:03 6 use weird Midwest words and they would just look at

10:03 7 me like I was crazy. So this was generally my

10:03 8 warning, like, if you don't understand a word I use

10:03 9 or if I'm using a weird word, I probably have

10:03 10 adopted some Colorado words over the years. Just

10:03 11 go ahead and ask me to clarify, and I'll do it. Is

10:04 12 that okay?

10:04 13 A. That is fine. And English isn't my

10:04 14 first language, so I may use some odd words myself.

10:04 15 Q. Fair enough. The last one is, if you

10:04 16 need a break, I'm happy to let you take one. The

10:04 17 only thing that I ask of you is that you answer the

10:04 18 last question that I posed before we take a break.

10:04 19 Is that okay?

10:04 20 A. Sure.

10:04 21 Q. Okay. Now, there might be points in

10:04 22 time where your counsel objects. You have been

10:04 23 through this before. You know you still have to

10:04 24 answer the question unless he instructs you not to?

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10:04 1 A. I understand.

10:04 2 Q. Now, is there any reason why you feel

10:04 3 like you cannot answer truthfully and accurately in

10:04 4 this deposition today?

10:04 5 A. Yes.

10:04 6 MS. REED: Ms. Court Reporter, could you read

10:04 7 back my question. I want to give Dr. Funk another

10:04 8 chance to answer it.

10:04 9 (WHEREUPON, the record was read by

10:05 10 the reporter.)

10:05 11 MR. LOMBARDO: So, Dr. Funk, you answered,

10:05 12 yes, there was a reason you could not testify

10:05 13 truthfully today.

10:05 14 THE WITNESS: No, that is not correct.

10:05 15 MR. LOMBARDO: Okay. Do you want to change

10:05 16 your answer?

10:05 17 THE WITNESS: No. My answer is correct.

10:05 18 BY MS. REED:

10:05 19 Q. Let me ask a different question, try it

10:05 20 a different way.

10:05 21 Dr. Funk, are you able to give your best

10:05 22 and most accurate testimony today?

10:05 23 A. My best and most accurate, is what you

10:05 24 asked?

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10:05 1 Q. Yes.

10:05 2 A. To the best of my knowledge I would be

10:05 3 able to do that, yes.

10:05 4 Q. Okay. And is there any reason that you

10:05 5 can think of sitting here today that you would not

10:06 6 be able to give your best testimony today?

10:06 7 A. No, not that I wouldn't at the time I

10:06 8 was asked the question. I sometimes may remember

10:06 9 facts later on. People refer to that as having

10:06 10 their memory refreshed or being refreshed, so that

10:06 11 occurs sometimes. So other than that, no, I would

10:06 12 not know of any other reason.

10:06 13 Q. Okay. Fair enough. Just to give you

10:06 14 some background, like I said, I practiced in

10:06 15 Colorado, so this is essentially my veiled way of

10:06 16 saying, Did you smoke weed this morning before this

10:06 17 deposition? It's just a standard question to make

10:06 18 sure that you are able to answer everything. Okay?

10:06 19 A. I understand. I'm just trying to answer

10:06 20 your questions accurately.

10:06 21 Q. Yes. I appreciate that. Now, those are

10:06 22 the ground rules.

10:06 23 Could you state and spell your name for

10:07 24 the record?

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10:07 1 A. Yes, Arthur Funk, A-r-t-h-u-r, F-u-n-k.

10:07 2 Q. And you had mentioned that you had been

10:07 3 deposed before; is that correct?

10:07 4 A. Yes.

10:07 5 Q. And how many times?

10:07 6 A. Lots.

10:07 7 Q. Can you give me a rough estimate?

10:07 8 A. I would say between 400 and 500.

10:07 9 Q. Okay. And have you been a 30(b)(6) --

10:07 10 or strike that.

10:07 11 Have you been a corporate representative

10:07 12 in a deposition for Wexford before?

10:07 13 A. Yes.

10:07 14 Q. And about how many times?

10:07 15 A. More than 200. Between 200 and 300, I

10:07 16 would guess.

10:07 17 Q. And what about within the last year,

10:07 18 have you acted as a corporate representative in a

10:07 19 deposition for Wexford?

10:07 20 A. This calendar year or the last

10:07 21 12 months?

10:07 22 Q. The last 12 months.

10:07 23 A. Yes. Of course, yes.

10:08 24 Q. How many times within the last

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<p>10:08 1 12 months?</p> <p>10:08 2 A. Again, I don't keep track, so I'm just</p> <p>10:08 3 guessing off the top of my head. Probably 30, 40,</p> <p>10:08 4 somewhere around there.</p> <p>10:08 5 Q. Do you recall if any of those</p> <p>10:08 6 depositions involved a rheumatoid arthritis</p> <p>10:08 7 diagnosis?</p> <p>10:08 8 A. Not that I recall. I don't think so,</p> <p>10:08 9 but perhaps. Again, there's been many, but I don't</p> <p>10:08 10 believe any were from -- about rheumatoid</p> <p>10:08 11 arthritis.</p> <p>10:08 12 Q. Okay. About when did you find out that</p> <p>10:09 13 you would have to appear for this deposition today?</p> <p>10:09 14 A. I didn't -- I was never told I had to</p> <p>10:09 15 appear. I volunteered to be the 30(b)(6)</p> <p>10:09 16 representative, and I don't remember when. It was</p> <p>10:09 17 some months ago, but I don't keep track of things</p> <p>10:09 18 like that. So it was months ago.</p> <p>10:09 19 Q. All right. Now, you mentioned that you</p> <p>10:09 20 volunteered to be the 30(b)(6) representative. Are</p> <p>10:09 21 there other people in your office that you know of</p> <p>10:09 22 who act as corporate representatives in these types</p> <p>10:09 23 of cases?</p> <p>10:09 24 A. Not in my office. In the corporation</p>	<p>10:11 1 a separate one?</p> <p>10:11 2 A. That's correct, yes.</p> <p>10:11 3 Q. Okay. Did you do anything to prepare</p> <p>10:11 4 for this deposition today?</p> <p>10:11 5 A. Yes.</p> <p>10:11 6 Q. Can you tell me -- can you describe</p> <p>10:11 7 generally what you did to prepare for this</p> <p>10:11 8 deposition?</p> <p>10:11 9 A. Primarily, I reviewed records that</p> <p>10:11 10 Mr. Lombardo had provided to me and other documents</p> <p>10:11 11 related to the deposition.</p> <p>10:11 12 Q. Did you conduct any searches on your own</p> <p>10:11 13 for documents related to this deposition?</p> <p>10:11 14 A. No. I would have -- at the time the</p> <p>10:11 15 litigation was first filed, I would have</p> <p>10:11 16 participated in a litigation hold, it's called,</p> <p>10:11 17 from the company, where any documents relative to</p> <p>10:12 18 the complaint would have been forwarded to the risk</p> <p>10:12 19 management office, but I did not do that recently.</p> <p>10:12 20 Q. And just to clarify, can you say with</p> <p>10:12 21 relative certainty that you did, in fact,</p> <p>10:12 22 participate in the litigation hold process for this</p> <p>10:12 23 case, or do you just typically participate in that?</p> <p>10:12 24 A. That is my practice, and I believe I</p>
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<p>10:09 1 there are, yes.</p> <p>10:09 2 Q. Where is your office located?</p> <p>10:09 3 A. In Chicago.</p> <p>10:10 4 Q. And can you state your business address</p> <p>10:10 5 for the record?</p> <p>10:10 6 A. No. I can be contacted through my</p> <p>10:10 7 attorney.</p> <p>10:10 8 MR. LOMBARDO: Jasmine, I think we are going</p> <p>10:10 9 to make an objection just for security purposes. I</p> <p>10:10 10 think that Dr. Funk has a home office, so his home</p> <p>10:10 11 office and business office would be the same. And</p> <p>10:10 12 just because of Mr. Daniels' record, for security</p> <p>10:10 13 purposes we'll object to that.</p> <p>10:10 14 He could give you Wexford's corporate</p> <p>10:10 15 office in Pittsburgh, but that is not where he is</p> <p>10:10 16 actually physically located, if you want that.</p> <p>10:10 17 BY THE WITNESS:</p> <p>10:10 18 A. I can certainly give you that address,</p> <p>10:10 19 if you would like.</p> <p>10:10 20 BY MS. REED:</p> <p>10:10 21 Q. I guess I just need you to confirm for</p> <p>10:10 22 the record -- and I note that your attorney did it,</p> <p>10:10 23 but I just need you to say it -- that your office</p> <p>10:10 24 is not the actual corporate headquarters. You have</p>	<p>10:12 1 did. I have no reason to believe I didn't.</p> <p>10:12 2 Q. Okay. Other than reviewing records and</p> <p>10:12 3 documents, did you do anything else to prepare for</p> <p>10:12 4 the deposition?</p> <p>10:12 5 A. I reviewed the standards of care for</p> <p>10:13 6 rheumatoid arthritis and some related disorders.</p> <p>10:13 7 That is all -- that is the only other thing I</p> <p>10:13 8 recall having done.</p> <p>10:13 9 Q. Okay. Did you speak with anyone in</p> <p>10:13 10 preparation for the deposition?</p> <p>10:13 11 A. Just counsel, Mr. Lombardo, and I would</p> <p>10:13 12 have communicated with the director of risk</p> <p>10:13 13 management at the corporate office, Mr. Joe Ebbitt,</p> <p>10:13 14 but that was just in regards to scheduling of the</p> <p>10:13 15 deposition.</p> <p>10:14 16 Q. When you were preparing for the</p> <p>10:14 17 deposition, about how many times did you speak</p> <p>10:14 18 with, say via phone or video conference or in</p> <p>10:14 19 person, Mr. Lombardo?</p> <p>10:14 20 A. I think it was three or four times, but</p> <p>10:14 21 the conversations would not have been restricted to</p> <p>10:14 22 this claim. It would have been any other claims</p> <p>10:14 23 that were pending that he was involved -- or we</p> <p>10:14 24 were both involved in.</p>

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10:14 1 Q. Okay. And of those three or four times,  
10:14 2 can you give me an estimate of the percentage of  
10:14 3 that time that was spent actually speaking about  
10:14 4 this deposition for this case?

10:15 5 A. It would have been the majority of the  
10:15 6 time, but I can't estimate what percent.

10:15 7 Q. Okay. And about how long did these  
10:15 8 conversations last?

10:15 9 A. Less than an hour, more than ten  
10:15 10 minutes. Between ten minutes and, I would say,  
10:15 11 45 minutes, is what I would guess.

10:15 12 Q. Okay. I'm going to show you what will  
10:15 13 be marked as the first exhibit for this deposition.  
10:16 14 Okay. So how this works is, I'm going to type the  
10:16 15 exhibit number in the chat and then attach the  
10:16 16 document, just to make sure everyone has it.

10:17 17 Okay. So, Dr. Funk, can you see my  
10:17 18 screen now?

10:17 19 A. Yes, I can.

10:17 20 Q. And is that font size fine, or do I need  
10:17 21 to blow it up a little bit?

10:17 22 A. You'd need to blow it up for me to  
10:17 23 actually read the print.

10:17 24 Q. Okay. How is that?

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10:18 1 A. That's a lot better.

10:18 2 Q. Okay. So I'm showing you what has been  
10:18 3 marked as Exhibit 1 for the deposition, and it's  
10:18 4 titled Second Amended Notice of Rule 30(b)(6)  
10:18 5 Remote Video Conference Deposition for Wexford  
10:18 6 Health Sources, Incorporated. Did I read that  
10:18 7 accurately?

10:18 8 A. Yes.

10:18 9 Q. I'm going to slowly scroll through this.  
10:18 10 So before today, had you seen this notice of  
10:18 11 deposition before?

10:18 12 A. Yes. It appears to be what I was  
10:18 13 provided by Mr. Lombardo.

10:18 14 Q. Okay. So now I'm going to go through  
10:18 15 each of the topics and ask you if you are prepared  
10:19 16 to testify about them today, so you know where I'm  
10:19 17 going with this.

10:19 18 We are starting on page 2 of Exhibit  
10:19 19 No. 1, Topic No. 1 reads, Policies related to  
10:19 20 medical treatment of prisoners at Illinois  
10:19 21 Department of Corrections.

10:19 22 Are you prepared to testify about Topic  
10:19 23 No. 1 today?

10:19 24 A. Yes.

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10:19 1 Q. Okay. And how did you get prepared?

10:19 2 A. As I stated, by reviewing the  
10:19 3 information that was provided to me, my familiarity  
10:19 4 from my working in the department of corrections,  
10:19 5 and, specifically, for Wexford Health Sources.

10:19 6 Q. Okay. And I know it's repetitive, but  
10:19 7 I'm going to have to ask you the same question for  
10:19 8 every one. I understand that you'll say, As I just  
10:19 9 said. I'm just letting you know, I just have to  
10:19 10 make the record.

10:19 11 A. Sure.

10:19 12 Q. So Topic No. 2, Policies, procedures,  
10:19 13 and protocols for treatment of serious medical  
10:20 14 conditions, serious medical needs, or chronic  
10:20 15 medical conditions, including but not limited to,  
10:20 16 joint pain, arthritis, rheumatoid arthritis,  
10:20 17 elevated Rh factors, ulcers, abdominal pain, GERD,  
10:20 18 acid reflux, and gastritis.

10:20 19 Are you prepared to testify about Topic  
10:20 20 No. 2, as I just read it?

10:20 21 A. Yes.

10:20 22 Q. And how are you prepared to testify  
10:20 23 about it?

10:20 24 A. The same response as to No. 1.

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10:20 1 Q. Okay. Topic No. 3, Policies,  
10:20 2 procedures, and protocols for screening inmates  
10:20 3 with serious medical conditions, serious medical  
10:20 4 needs, or chronic medical conditions including, but  
10:20 5 not limited to, joint pain, arthritis, rheumatoid  
10:20 6 arthritis, elevated Rh factors, ulcers, abdominal  
10:20 7 pain, GERD, acid reflux, and gastritis.

10:21 8 Are you prepared to testify concerning  
10:21 9 Topic No. 3, as I have just read it?

10:21 10 A. Yes.

10:21 11 Q. And how did you prepare yourself to  
10:21 12 testify on Topic No. 3?

10:21 13 A. The same response as Topic No. 1.

10:21 14 Q. Topic No. 4, Policies, procedures, and  
10:21 15 protocols for requesting outside medical tests  
10:21 16 and/or consultations with outside medical  
10:21 17 specialists.

10:21 18 Are you prepared to testify on Topic  
10:21 19 No. 4, as I just read it?

10:21 20 A. Yes.

10:21 21 Q. And how did you prepare to testify for  
10:21 22 Topic No. 4?

10:21 23 A. The same response as No. 1.

10:21 24 Q. Topic No. 5, Policies for participation

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10:21 1 in grievance process at IDOC. Are you prepared to  
 10:21 2 testify about Topic No. 5, as I just read it?  
 10:21 3 A. Yes.  
 10:21 4 Q. And how did you prepare yourself to  
 10:21 5 testify about Topic No. 5?  
 10:21 6 A. Again. Same response as No. 1.  
 10:22 7 Q. Topic No. 6, Policies, procedures, and  
 10:22 8 protocols for ordered medication not on the  
 10:22 9 approved medication list. Are you prepared to  
 10:22 10 testify about Topic No. 6, as I just read it?  
 10:22 11 A. Yes.  
 10:22 12 Q. And how did you prepare yourself to  
 10:22 13 testify for Topic No. 6?  
 10:22 14 A. Again, same response as to No. 1.  
 10:22 15 Q. Okay. Topic No. 7, Policy to ensure  
 10:22 16 that all medical services are provided in  
 10:22 17 accordance with medically accepted community  
 10:22 18 standards of care.  
 10:22 19 Are you prepared to testify about Topic  
 10:22 20 No. 7, as I just read it?  
 10:22 21 A. Yes.  
 10:22 22 Q. And how did you prepare yourself to  
 10:22 23 testify about Topic No. 7?  
 10:22 24 A. Again, same response as to No. 1.

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10:22 1 Q. Topic No. 8, Point of contact for  
 10:22 2 interaction between IDOC and Wexford. Are you  
 10:22 3 prepared to testify about Topic No. 8, as I just  
 10:22 4 read it?  
 10:22 5 A. Yes.  
 10:22 6 Q. And how did you prepare yourself to  
 10:22 7 testify about Topic No. 8?  
 10:23 8 A. Same response as to No. 1.  
 10:23 9 Q. Okay. Topic No. 9, Policies,  
 10:23 10 procedures, and protocols for Wexford's internal  
 10:23 11 review of inmates' medical records.  
 10:23 12 Are you prepared to testify about Topic  
 10:23 13 No. 9, as I just read it?  
 10:23 14 A. Yes.  
 10:23 15 Q. How did you prepare yourself to testify  
 10:23 16 about Topic No. 9?  
 10:23 17 A. The same response as to No. 1.  
 10:23 18 Q. Topic No. 10, Intake, treatment, and  
 10:23 19 screening of plaintiff. Are you prepared to  
 10:23 20 testify about Topic No. 10, as I just read it?  
 10:23 21 A. Yes.  
 10:23 22 Q. And how did you prepare yourself to  
 10:23 23 testify about Topic No. 10?  
 10:23 24 A. Same response as to No. 1.

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10:23 1 Q. Okay. Topic No. 11, Wexford's  
 10:23 2 correspondence and/or communications with Saleh  
 10:23 3 Obaisi, M.D., and/or LaTonya Williams regarding the  
 10:23 4 treatment of plaintiff.  
 10:23 5 Are you prepared to testify about Topic  
 10:23 6 No. 11, as I just read it?  
 10:23 7 A. Yes.  
 10:23 8 Q. And how did you prepare yourself to  
 10:23 9 testify about Topic No. 11?  
 10:24 10 A. Same response as to No. 1.  
 10:24 11 Q. Topic No. 12, Wexford's correspondence  
 10:24 12 and/or communications with physicians and/or other  
 10:24 13 health care professionals regarding the treatment  
 10:24 14 of plaintiff.  
 10:24 15 Are you prepared to testify about Topic  
 10:24 16 No. 12, as I just read it?  
 10:24 17 A. Yes.  
 10:24 18 Q. And how did you prepare yourself to  
 10:24 19 testify about Topic No. 12?  
 10:24 20 A. Same response as to No. 1.  
 10:24 21 Q. Okay. Topic No. 13, Policies,  
 10:24 22 procedures, and protocols related to the diagnosis  
 10:24 23 and/or administration of prescription medications  
 10:24 24 including, without limitation, any related to

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10:24 1 inappropriately accelerated diseases.  
 10:24 2 Are you prepared to testify about Topic  
 10:24 3 No. 13?  
 10:24 4 A. Yes.  
 10:24 5 Q. How did you prepare yourself to testify  
 10:24 6 about Topic No. 13?  
 10:24 7 A. Same response as to No. 1.  
 10:24 8 Q. Topic No. 14, Policies, procedures, and  
 10:24 9 protocols related to intake, medical treatment, and  
 10:24 10 screening inmates for medical conditions at IDOC.  
 10:25 11 Are you prepared to testify about Topic  
 10:25 12 No. 14, as I just read it?  
 10:25 13 A. Yes.  
 10:25 14 Q. And how did you prepare yourself to  
 10:25 15 testify about Topic No. 14?  
 10:25 16 A. Same response as to No. 1.  
 10:25 17 Q. Okay. Topic No. 15, Policies,  
 10:25 18 procedures, and protocols related to handling sick  
 10:25 19 call records, medical call reports, incident  
 10:25 20 reports, and monitoring of inmates.  
 10:25 21 Are you prepared to testify about Topic  
 10:25 22 No. 15, as I just read it?  
 10:25 23 A. Yes.  
 10:25 24 Q. And how did you prepare yourself to

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<p>10:25 1 testify about Topic No. 15?</p> <p>10:25 2 A. Same response as to No. 1.</p> <p>10:25 3 Q. Topic No. 16, Policies and -- policies</p> <p>10:25 4 and related to the prescription and/or</p> <p>10:25 5 administration of prescription medication.</p> <p>10:25 6 Are you prepared to testify about Topic</p> <p>10:25 7 No. 16, as I just read it?</p> <p>10:25 8 A. Yes.</p> <p>10:25 9 Q. Okay. And how did you prepare yourself</p> <p>10:25 10 to testify about Topic No. 16?</p> <p>10:25 11 A. Same response as to No. 1.</p> <p>10:25 12 Q. Okay. Topic No. 17, Wexford's document</p> <p>10:26 13 retention policies regarding documents that are</p> <p>10:26 14 relevant to this lawsuit.</p> <p>10:26 15 Are you prepared to testify about Topic</p> <p>10:26 16 No. 17, as I just read it?</p> <p>10:26 17 A. Yes.</p> <p>10:26 18 Q. Okay. How did you prepare yourself to</p> <p>10:26 19 testify about Topic No. 17?</p> <p>10:26 20 A. Same response as to No. 1.</p> <p>10:26 21 Q. Okay. That is the end of the topics.</p> <p>10:26 22 Now I'm going to dig a little further</p> <p>10:26 23 into your response to Topic No. 1 and how you</p> <p>10:26 24 prepared, as it applies to all of the topics.</p>	<p>10:28 1 Q. That last thing, did you say utilization</p> <p>10:28 2 management records?</p> <p>10:28 3 A. Yes.</p> <p>10:28 4 Q. So my list consists of, for the</p> <p>10:28 5 documents that you remember reviewing, medical</p> <p>10:28 6 records, legal correspondence, grievances, Wexford</p> <p>10:28 7 guidelines, the deposition of plaintiff, and</p> <p>10:28 8 utilization management records. Is there anything</p> <p>10:28 9 else that you can think of?</p> <p>10:28 10 A. I said legal correspondences or legal</p> <p>10:28 11 documents in the plural, not in the singular.</p> <p>10:28 12 Q. Okay. Anything else?</p> <p>10:28 13 A. Well, this deposition notice and some</p> <p>10:28 14 other documents, but, no, I don't recall anything</p> <p>10:28 15 else.</p> <p>10:28 16 Q. The medical records that you reviewed,</p> <p>10:29 17 what institution did those medical records come</p> <p>10:29 18 from?</p> <p>10:29 19 A. Several.</p> <p>10:29 20 Q. Which ones?</p> <p>10:29 21 A. Primarily, the Department of</p> <p>10:29 22 Corrections. A rheumatologist that was in Illinois</p> <p>10:29 23 but from his office somewhere in Central Illinois,</p> <p>10:29 24 and then just yesterday afternoon, I received some</p>
Page 22	Page 24
<p>10:26 1 Now, earlier when we talked about what</p> <p>10:26 2 you did to prepare, you said that you reviewed</p> <p>10:26 3 records and other documents; is that correct?</p> <p>10:26 4 A. Yes.</p> <p>10:26 5 Q. Okay. And you also said that you</p> <p>10:26 6 reviewed the standards of care of rheumatoid</p> <p>10:26 7 arthritis and other diseases?</p> <p>10:26 8 A. For rheumatoid related diseases, is what</p> <p>10:26 9 I said, yes.</p> <p>10:26 10 Q. Okay. Related. I apologize. Let's</p> <p>10:27 11 start with the records you reviewed.</p> <p>10:27 12 First of all, what types of records did</p> <p>10:27 13 you review for this file?</p> <p>10:27 14 A. The records that were provided by</p> <p>10:27 15 Mr. Lombardo.</p> <p>10:27 16 Q. And what did those records consist of?</p> <p>10:27 17 A. There were medical records. There were</p> <p>10:27 18 different legal correspondences and documents. I</p> <p>10:27 19 recall two grievances. There were some Wexford</p> <p>10:27 20 guidelines or policies. The deposition of the</p> <p>10:27 21 plaintiff and some utilization management records.</p> <p>10:28 22 That is what I recall, but there may have been some</p> <p>10:28 23 other documents. It's been some time since I</p> <p>10:28 24 reviewed them.</p>	<p>10:29 1 records from Mr. Lombardo from the Cook County</p> <p>10:29 2 Health System for treatment of the plaintiff for</p> <p>10:29 3 four visits that he had there.</p> <p>10:29 4 Q. Okay. Any other institutions that you</p> <p>10:29 5 can recall?</p> <p>10:30 6 A. He may have had some testing at other</p> <p>10:30 7 facilities that I did not mention, but I don't know</p> <p>10:30 8 the name of them, as I'm sitting here right now.</p> <p>10:30 9 Q. Do you have those documents with you?</p> <p>10:30 10 A. No.</p> <p>10:30 11 Q. How were those documents sent to you?</p> <p>10:30 12 A. Via courier primarily. The records I</p> <p>10:30 13 received yesterday afternoon were scanned and sent</p> <p>10:30 14 electronically.</p> <p>10:30 15 Q. Okay. Now, the legal correspondence, I</p> <p>10:30 16 don't want to get into communications between you</p> <p>10:30 17 and your attorney, so can you just generally</p> <p>10:30 18 describe what you meant by legal correspondences?</p> <p>10:31 19 A. The different legal documents, such as</p> <p>10:31 20 the response to interrogatories, like this notice</p> <p>10:31 21 of deposition, the things like requests to admit,</p> <p>10:31 22 things like that.</p> <p>10:31 23 Q. Okay. And by grievances, were you</p> <p>10:31 24 referring to the plaintiff's grievances that he</p>



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<p>10:31 1 filed?</p> <p>10:31 2 A. Yes. I believe there were two, yes.</p> <p>10:31 3 Q. Now, let's discuss the Wexford</p> <p>10:31 4 guidelines that you reviewed. Was that one</p> <p>10:31 5 document, or was it multiple sets of guidelines?</p> <p>10:32 6 A. There were portions taken out of</p> <p>10:32 7 guidelines that -- I believe there were more than</p> <p>10:32 8 one. I just scanned those. They were also just</p> <p>10:32 9 provided yesterday afternoon.</p> <p>10:32 10 Q. Were those provided via e-mail?</p> <p>10:32 11 A. Yes.</p> <p>10:32 12 Q. All right. Do you recall the names of</p> <p>10:32 13 those guidelines?</p> <p>10:32 14 A. Medical guidelines and medical policies</p> <p>10:32 15 and procedures, one or the other.</p> <p>10:32 16 Q. Any other names or guidelines?</p> <p>10:32 17 A. Not that I recall. I did not really</p> <p>10:32 18 have time because of the short notice to review</p> <p>10:33 19 them, but I have reviewed those -- all of Wexford's</p> <p>10:33 20 documents for other depositions, so I did not feel</p> <p>10:33 21 that I had a need to look at it specifically.</p> <p>10:33 22 Q. Okay. And by deposition of the</p> <p>10:33 23 plaintiff, you mean the plaintiff in this case,</p> <p>10:33 24 correct?</p>	<p>10:35 1 you describe for me what you reviewed to determine</p> <p>10:35 2 the standards of care for rheumatoid arthritis?</p> <p>10:35 3 A. I reviewed documents that were published</p> <p>10:36 4 by a source called UpToDate. It's a medical</p> <p>10:36 5 reference that clinicians use.</p> <p>10:36 6 Q. Is this an online resource?</p> <p>10:36 7 A. Yes.</p> <p>10:36 8 Q. Anything else?</p> <p>10:36 9 A. No, that is what I recall.</p> <p>10:36 10 Q. Okay. So the documents by UpToDate</p> <p>10:36 11 covered standards for rheumatoid arthritis and</p> <p>10:36 12 related diseases?</p> <p>10:36 13 A. Yes. That is not all it contains, but</p> <p>10:36 14 it has those illnesses and many other illnesses.</p> <p>10:36 15 Q. Okay. Did you speak with any of the</p> <p>10:37 16 employees involved in this lawsuit to prep for the</p> <p>10:37 17 deposition?</p> <p>10:37 18 A. No.</p> <p>10:37 19 Q. Okay. Other than your attorney and the</p> <p>10:37 20 risk management person, do you recall speaking with</p> <p>10:37 21 anyone else to prepare for this deposition?</p> <p>10:37 22 A. No.</p> <p>10:37 23 Q. Okay. You mentioned that you are</p> <p>10:38 24 familiar with Wexford's procedures based on your</p>
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<p>10:33 1 A. Yes.</p> <p>10:33 2 Q. Now, describe for me what utilization</p> <p>10:33 3 management records are.</p> <p>10:33 4 A. They are records generated from</p> <p>10:33 5 Wexford's utilization management department</p> <p>10:33 6 regarding services that are primarily done outside</p> <p>10:33 7 of the facility, that is of the correctional</p> <p>10:33 8 facility where the plaintiff was housed.</p> <p>10:33 9 Q. Can you give me an example?</p> <p>10:34 10 A. They appear as screen shots, a computer</p> <p>10:34 11 screen shot with information written in it that</p> <p>10:34 12 pertains to Mr. Daniels, so it would have his</p> <p>10:34 13 identifying information and clinical information,</p> <p>10:34 14 such as what service or study was requested and</p> <p>10:34 15 then a summary of the conversation and</p> <p>10:34 16 justification for that service.</p> <p>10:34 17 Q. Who fills out these or who creates or</p> <p>10:34 18 develops these records, the utilization management</p> <p>10:35 19 records?</p> <p>10:35 20 A. The utilization management nurse in the</p> <p>10:35 21 corporate office in Pittsburgh.</p> <p>10:35 22 Q. Okay. Now, let's switch to the</p> <p>10:35 23 standards of care for rheumatoid arthritis, the</p> <p>10:35 24 documents that you reviewed concerning that. Can</p>	<p>10:38 1 own experience; is that accurate?</p> <p>10:38 2 A. Yes.</p> <p>10:38 3 Q. Okay. So now I'm just going to ask you</p> <p>10:38 4 some background questions, so I understand what</p> <p>10:38 5 your experience is. Is that okay?</p> <p>10:38 6 A. Sure.</p> <p>10:38 7 Q. Your current position is the regional</p> <p>10:38 8 medical director for Wexford; is that correct?</p> <p>10:38 9 A. For Illinois.</p> <p>10:38 10 Q. For Illinois. How long have you been in</p> <p>10:38 11 that position?</p> <p>10:38 12 A. Since 2005.</p> <p>10:38 13 Q. And what did you do before that,</p> <p>10:38 14 immediately before?</p> <p>10:38 15 A. I was site medical director for a</p> <p>10:39 16 facility in Illinois, and I also -- for about six</p> <p>10:39 17 or eight months, as I remember, I performed</p> <p>10:39 18 utilization management functions for Wexford. That</p> <p>10:39 19 was in 2004 to 2005.</p> <p>10:39 20 Q. Okay. So you were the regional -- or</p> <p>10:39 21 you are the regional medical director and you have</p> <p>10:39 22 been the regional medical director of Illinois</p> <p>10:39 23 since 2005, correct?</p> <p>10:39 24 A. Yes.</p>

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10:39 1 Q. And prior to that, you were a site  
 10:40 2 medical director?  
 10:40 3 A. Correct.  
 10:40 4 Q. And how long were you a site medical  
 10:40 5 director?  
 10:40 6 A. Seven and a half years.  
 10:40 7 Q. And then concurrently with that  
 10:40 8 position, you also had some utilization management  
 10:40 9 duties from 2004 to 2005; is that correct?  
 10:40 10 A. Yes.  
 10:40 11 Q. When you were a site director, could you  
 10:40 12 just generally describe for me what your duties  
 10:40 13 were?  
 10:40 14 A. Clinical and administrative duties for  
 10:40 15 the facility, and I supervised the clinical staff  
 10:40 16 at the facility.  
 10:40 17 Q. And can you give me a little bit more  
 10:41 18 detail about what it means to supervise the  
 10:41 19 clinical staff at the facility?  
 10:41 20 A. Yes. I oversaw the services, the health  
 10:41 21 care services that were delivered from all of the  
 10:41 22 different departments at the facility, nursing,  
 10:41 23 radiology, phlebotomy, dental, mental health, and  
 10:41 24 then clinical. And then I was the direct

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10:41 1 supervisor of the physicians, the staff physicians,  
 10:41 2 that provided the direct care to the population.  
 10:41 3 Q. As a site medical director, were you  
 10:41 4 involved with training of the physicians when they  
 10:42 5 started?  
 10:42 6 A. Yes.  
 10:42 7 Q. Can you give me an overview of what the  
 10:42 8 training entailed for a new physician at the site?  
 10:42 9 A. Yes. It consisted primarily of  
 10:42 10 Wexford's orientation program and then some related  
 10:42 11 documents that would have been applicable at the  
 10:42 12 time of the orientation.  
 10:42 13 Q. What types of documents?  
 10:42 14 A. The provider handbook, policies from the  
 10:42 15 State, different guidelines from the State,  
 10:42 16 practices of the facility, the job description.  
 10:43 17 And it would also include -- and it would depend on  
 10:43 18 the individual candidate as to their experience,  
 10:43 19 the clinical experience and whether they have  
 10:43 20 correctional experience, but it would also include  
 10:43 21 some mentoring that would either be done by me --  
 10:43 22 myself or with another physician.  
 10:43 23 Q. Okay. Let's switch to your utilization  
 10:43 24 management duties. Could you just give me a brief

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10:43 1 summary of what that entailed?  
 10:43 2 A. Wexford has a utilization management  
 10:43 3 function called collegial review, where a physician  
 10:43 4 reviews the requests by another physician. Those  
 10:43 5 are requests for services outside of the facility.  
 10:44 6 It is a teleconference meeting that consists of the  
 10:44 7 physician who is making the request, a utilization  
 10:44 8 management nurse, utilization management physician,  
 10:44 9 in which case I was fulfilling that role, and the  
 10:44 10 site scheduler. That is the person who schedules  
 10:44 11 the request.  
 10:44 12 It consists at least of those four  
 10:44 13 individuals, but sometimes others may join on the  
 10:44 14 call, such as the health care unit administrator or  
 10:44 15 director of nursing or somebody -- sometimes  
 10:44 16 somebody from the administrative staff at the  
 10:44 17 facility. And the call consists of the request,  
 10:44 18 and then the review of the person's request, a  
 10:44 19 discussion ensues and then a decision is made as to  
 10:44 20 the best course of treatment consistent with the  
 10:45 21 contract and the community standard of care.  
 10:45 22 Q. So is it fair to say that the purpose of  
 10:45 23 those collegial reviews was to determine whether  
 10:45 24 the patient should be referred outside of the

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10:45 1 facility to another physician?  
 10:45 2 A. Whether it was appropriate, yes.  
 10:45 3 Q. And what were some reasons that during  
 10:45 4 your tenure you would deny that request?  
 10:45 5 A. If it was not covered by the contract,  
 10:45 6 not a service that we were to provide by the  
 10:45 7 contract, or if it was not clinically consistent or  
 10:45 8 reasonable or there was a better course of action.  
 10:46 9 Q. Can you give me a little bit more detail  
 10:46 10 by what you mean by -- when you say something is  
 10:46 11 not covered by the contract?  
 10:46 12 A. Yes, for each facility, Wexford has a  
 10:46 13 contract to provide specific services, and it  
 10:46 14 details and defines what services we are to  
 10:46 15 provide, and then there are services that are not  
 10:46 16 covered or not provided.  
 10:46 17 So the first would be to determine  
 10:46 18 whether the service being requested was something  
 10:46 19 that was under our contract to provide.  
 10:46 20 Q. Can you give me an example of something  
 10:46 21 that would not be covered by the contract?  
 10:46 22 A. You are talking about Illinois?  
 10:46 23 Q. Yes.  
 10:46 24 A. Cosmetic procedures, organ transplant,



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10:47 1 treatment of Hepatitis C and HIV, medication  
 10:47 2 treatment I'm referring to, dialysis services at  
 10:47 3 the time. That has since changed. It's now under  
 10:47 4 our contract, but for most of the contract or the  
 10:47 5 time period in question, it would have been  
 10:47 6 dialysis services. Abortion services, sex change  
 10:47 7 services, sex reassignment services, surgical sex  
 10:47 8 reassignment.  
 10:47 9 Those are the ones that come to mind.  
 10:47 10 Again, the contract defines what we do primarily,  
 10:47 11 not what we don't do, but it does make reference to  
 10:47 12 certain illnesses that I mentioned that are the  
 10:47 13 Department of Corrections' responsibility.  
 10:47 14 Q. Okay. And so if something is not  
 10:47 15 covered by the contract and you tell the physician  
 10:47 16 from the site that it's not covered, then what is  
 10:48 17 the next step for that physician?  
 10:48 18 A. He would need to resolve that. He would  
 10:48 19 need to respond to that by telling the patient that  
 10:48 20 the service is not provided and why it's not  
 10:48 21 provided and then give them an avenue to whom -- to  
 10:48 22 request that service.  
 10:48 23 Q. Okay. In your current role, are you  
 10:48 24 still familiar with the utilization management

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10:50 1 regional medical director for Illinois?  
 10:50 2 A. Yes. I perform clinical and  
 10:50 3 administrative duties as assigned to me by my  
 10:50 4 supervisors.  
 10:50 5 Q. Who are your supervisors?  
 10:50 6 A. The clinical supervisor would be  
 10:50 7 Dr. Stephen Ritz, and then my administrative  
 10:50 8 supervisor would be Stacey Scott.  
 10:50 9 Q. What type of clinical duties does your  
 10:50 10 supervisor assign to you?  
 10:51 11 A. To supervise the medical directors at  
 10:51 12 the facilities that I'm assigned to and provide  
 10:51 13 direct care, when called for, review care provided  
 10:51 14 by other physicians. That may be the individuals  
 10:51 15 that I'm supervising or other staff at the  
 10:51 16 facility, but it would primarily be confined to the  
 10:51 17 facilities that I oversee.  
 10:51 18 Q. Okay. And what are some of your  
 10:51 19 administrative duties that are assigned to you from  
 10:51 20 your supervisor?  
 10:51 21 A. Well, responding to legal matters would  
 10:51 22 be one, such as this deposition. Related to that,  
 10:51 23 other claims that come from inmates, attending  
 10:52 24 meetings, reviewing data, information, things like

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10:48 1 duties?  
 10:48 2 A. Yes.  
 10:48 3 Q. Okay. And as you have just described,  
 10:48 4 the duties that you were doing from 2004 to 2005,  
 10:48 5 has that collegial review process stayed the same  
 10:48 6 throughout your tenure as the regional medical  
 10:48 7 director?  
 10:49 8 A. Different individuals were involved, but  
 10:49 9 recently the collegial review by -- my contract was  
 10:49 10 eliminated with the last contract renewal, which  
 10:49 11 was about nine months ago.  
 10:49 12 Q. Do you know why?  
 10:49 13 A. It was a request from the Department of  
 10:49 14 Corrections.  
 10:49 15 Q. Okay. So prior to the elimination of  
 10:49 16 the collegial review process, did that process stay  
 10:49 17 the same as you have described it to me today?  
 10:49 18 A. Yes, approximately the same. There were  
 10:49 19 tweaks with the policy that occurred over time,  
 10:49 20 refining it and clarifying, but the procedure  
 10:49 21 basically remained the same.  
 10:49 22 Q. Okay. Now, I'm going to pivot here to  
 10:50 23 your regional medical director position. Can you  
 10:50 24 generally describe for me your duties as the

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10:52 1 that.  
 10:52 2 Q. Okay. Do you have a separate medical  
 10:52 3 practice outside from your role as a regional  
 10:52 4 medical director for Illinois?  
 10:52 5 A. No.  
 10:52 6 Q. Okay. How long have you been employed  
 10:52 7 by Wexford?  
 10:52 8 A. Since 1995, with the exception of about  
 10:52 9 three years.  
 10:52 10 Q. Okay. Have you ever had a separate  
 10:53 11 medical practice?  
 10:53 12 A. Yes.  
 10:53 13 Q. Okay. When did that end?  
 10:53 14 A. 1993 abouts.  
 10:53 15 Q. Okay. Just so I understand the  
 10:53 16 hierarchy a little bit. Right now, when you  
 10:53 17 supervise medical directors, are you supervising  
 10:53 18 site medical directors, i.e., the prior position  
 10:53 19 that you had?  
 10:53 20 A. Correct. That's correct.  
 10:54 21 Q. Are you involved with hiring at all?  
 10:54 22 A. Yes.  
 10:54 23 Q. Okay. And what are your duties related  
 10:54 24 to hiring?

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10:54 1 A. I interview prospective applicants.  
 10:54 2 That is, either physicians or midlevel providers.  
 10:54 3 Q. And you --  
 10:54 4 A. Sorry. Just to clarify. Just for my  
 10:54 5 region, not for the entire state.  
 10:54 6 Q. When you say "your region" but "not the  
 10:54 7 entire state," which part of the state is your  
 10:54 8 region?  
 10:54 9 A. The northern part. The state is divided  
 10:54 10 into three for the regional medical director  
 10:55 11 districts, so there's a northern, a central, and a  
 10:55 12 southern. I'm the northern.  
 10:55 13 Q. So you are involved with interviewing  
 10:55 14 physicians that work at the sites; is that  
 10:55 15 accurate?  
 10:55 16 A. Yes.  
 10:55 17 Q. Okay. Is there a formal criteria or  
 10:55 18 list that a physician has to meet in order to be  
 10:55 19 employed at one of the sites?  
 10:55 20 A. There are requirements, yes.  
 10:55 21 Q. Okay. Are those requirements set forth  
 10:55 22 in any document?  
 10:55 23 A. Yes.  
 10:55 24 Q. What document is that?

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10:55 1 A. Well, in several documents, one of which  
 10:55 2 would be the job description would define what  
 10:56 3 services are -- what credentials are necessary.  
 10:56 4 It's also defined in the contract of what  
 10:56 5 credentials are necessary for each position.  
 10:56 6 Q. Now, when you refer to "the contract,"  
 10:56 7 is that the contract with that specific physician  
 10:56 8 or the contract that you have with the Department  
 10:56 9 of Corrections?  
 10:56 10 A. The contract that we have with the  
 10:56 11 Department of Corrections and Health and Family  
 10:56 12 Services.  
 10:56 13 Q. Okay. Once the physicians and other  
 10:56 14 employees are hired, are you involved with training  
 10:56 15 in your current role?  
 10:56 16 A. Yes.  
 10:56 17 Q. And what are your responsibilities  
 10:56 18 related to training?  
 10:56 19 A. Orientation of the physician or  
 10:56 20 sometimes midlevel provider, depending on the  
 10:57 21 individual circumstance.  
 10:57 22 Q. Other than the orientation, is there any  
 10:57 23 other type of training?  
 10:57 24 A. A mentoring process usually occurs,

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10:57 1 where the physician will work alongside another  
 10:57 2 physician, and then there's ongoing training that  
 10:57 3 occurs as the need arises.  
 10:57 4 Q. How frequent is the ongoing training?  
 10:57 5 A. As the need arises, so like -- excuse  
 10:57 6 me. Let me just get this.  
 10:57 7 (WHEREUPON, there was a short  
 10:57 8 interruption.)  
 10:57 9 BY THE WITNESS:  
 10:57 10 A. I'm sorry. I said, As the need arises.  
 10:57 11 BY MS. REED:  
 10:57 12 Q. Okay. So in your experience, how  
 10:57 13 typically does the need arise? Is it once a year,  
 10:58 14 more than that?  
 10:58 15 A. So it may be daily in some cases, but  
 10:58 16 then it may be several months. It depends on the  
 10:58 17 time the person was hired. It could be more  
 10:58 18 frequent or more -- it would be more relevant to  
 10:58 19 occur shortly after the person was hired, and then  
 10:58 20 if somebody has worked for several years, in some  
 10:58 21 cases we have had physicians that have worked for  
 10:58 22 over 30 years, there would be less interaction in  
 10:58 23 that instance. But whenever there was a change of  
 10:58 24 policy, there would be some discussion of that.

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10:58 1 Q. Okay. Are the physicians reviewed on a  
 10:58 2 regular basis?  
 10:58 3 A. Yes.  
 10:58 4 Q. Are you involved with the review of  
 10:58 5 their performance?  
 10:58 6 A. Of the physicians that I supervise, yes.  
 10:59 7 Q. And what does that entail?  
 10:59 8 A. Reviewing their performance as it  
 10:59 9 relates to their decisions that they make and their  
 10:59 10 functioning in their role, in their position. That  
 10:59 11 occurs on an ongoing basis.  
 10:59 12 Q. Do the physicians ever receive written  
 10:59 13 feedback on their performance?  
 10:59 14 A. Yes.  
 10:59 15 Q. How often do they receive written  
 10:59 16 feedback?  
 10:59 17 A. As called for. If there is a corrective  
 10:59 18 action that is necessary, they would certainly  
 10:59 19 receive correspondence, or in some cases if it's a  
 10:59 20 positive review, positive finding after review,  
 10:59 21 they may receive that or it may be done verbally.  
 10:59 22 Generally, it's done verbally, but it may occur in  
 10:59 23 writing. Then there are -- the corporation does  
 11:00 24 annual reviews of its employees. That also takes

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11:00 1 place.

11:00 2 Q. Okay. So is it fair to say the

11:00 3 physicians that you supervise are reviewed on an

11:00 4 annual basis and then as needed aside from that?

11:00 5 A. I would say the review occurs on an

11:00 6 ongoing basis as they make decisions and I critique

11:00 7 their decision-making process and their performance

11:00 8 in their position, whenever I have interaction of

11:00 9 that.

11:00 10 In addition, there's a review that

11:00 11 occurs, an annual review that occurs, that I may

11:00 12 participate in, but the review is on an ongoing

11:00 13 basis. It would not be reasonable to have a

11:00 14 deficiency unaddressed and reviewed at the end of

11:01 15 the year. It has to be done at the time so that

11:01 16 the review can be -- can be appropriate and any

11:01 17 response could be done in a timely manner.

11:01 18 Q. Let me dig into that a little bit. So

11:01 19 I'm trying to figure out, like, do you review every

11:01 20 decision they make, or is it just like there's a

11:01 21 certain level of decision that triggers your

11:01 22 review? I'm just trying to get --

11:01 23 A. No, only those that I'm involved in. So

11:01 24 I have nine facilities, there are nine medical

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11:01 1 directors. They are making decisions continually.

11:01 2 I obviously can't review all of those decisions.

11:01 3 Q. Right.

11:01 4 A. So it would only be those that came to

11:01 5 my attention that I had involvement with.

11:01 6 Q. Okay. And I just want to clarify, so

11:01 7 you review the site medical directors as well as

11:02 8 the physicians that work under those directors?

11:02 9 A. I review specific aspects of their work

11:02 10 for both the -- for the medical staff. That

11:02 11 includes site medical directors and physicians.

11:02 12 Some facilities don't have a physician in addition

11:02 13 to a medical director, a few of them actually only

11:02 14 do, but that would apply.

11:02 15 The direct supervisor of the physician

11:02 16 would be the medical director, so they would

11:02 17 actually be the supervisor that is responsible for

11:02 18 the oversight of that person's performance. But I

11:02 19 would also -- I'm an indirect supervisor of that

11:02 20 individual as well, and if something came to my

11:02 21 attention, I would review that event and the

11:02 22 performance and the response of that person in that

11:02 23 situation.

11:02 24 Q. Is there any type of situation that you

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11:02 1 can think of that is always going to be escalated

11:03 2 to you for review?

11:03 3 A. Not any specific matter, but anything of

11:03 4 significance would be escalated to me. I mean, if

11:03 5 there was a -- anything of significance. I can't

11:03 6 think of a specific matter. I mean, there are

11:03 7 certain diseases, like meningitis, for example,

11:03 8 it's an uncommon serious disease. That would

11:03 9 certainly be brought to my attention.

11:03 10 There are many other very significant,

11:03 11 very rare illnesses that certainly would come to my

11:03 12 attention, but I can't -- yeah, I can't really list

11:03 13 all of them.

11:03 14 Q. Can you list a few of them, just so I

11:04 15 get an idea of the types?

11:04 16 A. Well, meningitis. There is a syndrome

11:04 17 called neuroleptic malignant syndrome. An illness

11:04 18 that was unexpected and resulted in death. Serious

11:04 19 infections, like Ebola type of infections. There's

11:04 20 a disease called necrotizing fasciitis, which is a

11:04 21 very serious illness. That would be brought to my

11:04 22 attention. So those are the illnesses that would

11:04 23 be brought to my attention, but other matters

11:04 24 relating to the employee would be brought to my

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11:04 1 attention. Illness or, you know, death or

11:04 2 something like that has actually occurred with one

11:04 3 of the plaintiffs here. Things like that obviously

11:04 4 would be brought to my attention.

11:04 5 Q. So if a physician asked for an outside

11:05 6 referral, which triggered the collegial review,

11:05 7 would that be brought to your attention?

11:05 8 A. No.

11:05 9 Q. Okay.

11:05 10 A. Not in the current or in the recent.

11:05 11 Obviously, it did when I was performing that

11:05 12 function, and then when I took the position of

11:05 13 regional medical director, one of our duties was to

11:05 14 be the utilization management physician, do the

11:05 15 collegial review for our facilities. That went on

11:05 16 for about four or five years, as I remember, so

11:05 17 that would have been 2005 to 2009 or '10.

11:05 18 Then it was assigned to another

11:05 19 physician in the corporate office. It was removed

11:05 20 from our responsibilities.

11:06 21 Q. You mentioned that you had a separate

11:06 22 practice up until about 1993; is that correct?

11:06 23 A. Not a separate practice. I had a

11:06 24 practice.

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11:06 1 Q. Oh, you had a practice?  
 11:06 2 A. I did not have one in addition to  
 11:06 3 working for Wexford, I think is what you asked, but  
 11:06 4 I had my own medical practice, yes.  
 11:06 5 Q. And did you have a specialty?  
 11:06 6 A. Yes.  
 11:06 7 Q. What was your specialty?  
 11:06 8 A. Internal medicine.  
 11:06 9 Q. How long did you have that practice?  
 11:06 10 A. About eight years.  
 11:06 11 Q. Could you just generally recite your  
 11:07 12 education, your degrees that you have?  
 11:07 13 A. M.D. degree, University of Illinois, and  
 11:07 14 then after that, I did an internship and residency  
 11:07 15 in internal medicine, so my degree is M.D.  
 11:07 16 Q. Okay. And what year did you attain your  
 11:07 17 M.D.?  
 11:07 18 A. '82, 1982.  
 11:07 19 Q. Okay. And have you received or obtained  
 11:07 20 any other certifications related to your practice?  
 11:07 21 A. Yes.  
 11:07 22 Q. What certifications?  
 11:07 23 A. CCHP and board certification in internal  
 11:08 24 medicine.

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11:08 1 Q. What does CCHP stand for?  
 11:08 2 A. Certified correctional health care  
 11:08 3 provider.  
 11:08 4 Q. When did you receive that certification?  
 11:08 5 A. I don't recall the year. It would have  
 11:08 6 been in the '90s, sometime in the late '90s,  
 11:08 7 mid-'90s.  
 11:08 8 Q. Is that certification still active?  
 11:08 9 A. Yes.  
 11:08 10 Q. Okay. Do you have to participate in any  
 11:08 11 continuing education to keep that certification  
 11:08 12 active?  
 11:08 13 A. Yes.  
 11:08 14 Q. Okay. In your position as a regional  
 11:08 15 medical director, how often are you onsite at a  
 11:08 16 facility?  
 11:08 17 A. It varies. It's been different since  
 11:09 18 the advent of COVID, where we have gone mostly to  
 11:09 19 remote contact. So prior to COVID, most days. I  
 11:09 20 would say four out of five days I would be at a  
 11:09 21 site, three to four out of the week. Now, about  
 11:09 22 once a week.  
 11:09 23 Q. Did you have a particular schedule for  
 11:09 24 your site visits?

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11:09 1 A. There were some meetings that I would  
 11:09 2 attend, but few. Mostly it was on an as-needed  
 11:09 3 basis.  
 11:09 4 Q. Okay. Are you familiar with the  
 11:10 5 Stateville Correctional Center?  
 11:10 6 A. Yes.  
 11:10 7 Q. And have you been onsite at that  
 11:10 8 correctional center?  
 11:10 9 A. Yes.  
 11:10 10 Q. Has that always been one of the  
 11:10 11 facilities in your region?  
 11:10 12 A. Yes.  
 11:10 13 Q. And by "always," I mean since you became  
 11:10 14 the regional director.  
 11:10 15 A. Correct.  
 11:10 16 Q. Okay. Now, of the physicians that work  
 11:10 17 for the site medical directors, are physicians  
 11:10 18 assigned to a particular facility or do they tend  
 11:10 19 to rotate?  
 11:10 20 A. Generally, yes, they have a primary  
 11:10 21 position. In some cases there is a sharing, and  
 11:10 22 that would be limited in my region to Stateville  
 11:11 23 and its neighboring facility, Stateville NRC. They  
 11:11 24 are immediately adjacent, and they do share

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11:11 1 providers because of the unique demands of those  
 11:11 2 facilities.  
 11:11 3 Q. Okay. So have you observed physicians  
 11:11 4 meeting with patients at your facilities?  
 11:11 5 A. Yes.  
 11:11 6 Q. And can you describe for me the  
 11:12 7 procedures that they follow when meeting with the  
 11:12 8 patient?  
 11:12 9 A. Yes. They would introduce themselves.  
 11:12 10 They would have the patient seated. And then they  
 11:12 11 would conduct an interview while the chart was  
 11:12 12 present and determine the reason for the visit, and  
 11:12 13 then ask appropriate questions, give the patient an  
 11:12 14 opportunity to respond and to voice their concerns,  
 11:12 15 their medical concerns.  
 11:12 16 Then they would conduct an examination  
 11:12 17 and come to a decision for a plan of care, based  
 11:12 18 upon their findings. That would be documented in  
 11:13 19 the progress note of the chart. The patient would  
 11:13 20 be advised as to what the physician's thought  
 11:13 21 process was and what course of action was being  
 11:13 22 undertaken, and if medications were prescribed,  
 11:13 23 what they were, what the side effects were, and  
 11:13 24 what they were to expect in terms of when to

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11:13 1 receive the medication. And then subsequent care  
 11:13 2 that would be provided, whether that was X-rays or  
 11:13 3 blood tests or follow-up visits or a referral to  
 11:13 4 somebody. So that is a rough overview of what  
 11:13 5 occurs.

11:13 6 Q. Now, you mentioned they would conduct an  
 11:13 7 interview of the patient and they had the chart  
 11:13 8 with them during that interview; is that correct?

11:13 9 A. Yes.

11:13 10 Q. Okay. And was it standard practice for  
 11:14 11 the physicians to review the patient's prior  
 11:14 12 medical records or charts before seeing them?

11:14 13 A. As applicable to that visit. So that  
 11:14 14 may entail a review of that volume or sometimes  
 11:14 15 there's more volumes, or it may not. It depends on  
 11:14 16 the complaint.

11:14 17 Q. Okay. So there were some complaints  
 11:14 18 that would not require review of the prior medical  
 11:14 19 records?

11:14 20 A. Some complaints and some situations.  
 11:14 21 For example, a physician that had regularly seen a  
 11:14 22 patient would have knowledge of that patient's past  
 11:14 23 record and findings and wouldn't need to or they  
 11:14 24 may just scan it to refresh their memory or review

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11:14 1 their notes. But there are some conditions that --  
 11:14 2 where a review of the record would be very limited.  
 11:15 3 So I would -- I'll correct myself. It's not that  
 11:15 4 they wouldn't need to review it at all, but they  
 11:15 5 would not need to review it in depth.

11:15 6 Q. What types of conditions, for example?

11:15 7 A. If a person had a rash that had never  
 11:15 8 occurred before, there would be no need to look  
 11:15 9 through the patient's entire record, but you would  
 11:15 10 look at relevant things, such as their medications,  
 11:15 11 their allergy history, their general medical  
 11:15 12 conditions, if they have something called a problem  
 11:15 13 list. It would just be a review of a limited  
 11:15 14 portion of the record.

11:15 15 Q. Okay.

11:15 16 A. Or I'll give you another example. If  
 11:15 17 somebody has a fracture, if they are playing  
 11:15 18 basketball and they fracture their ankle, again,  
 11:15 19 the review would be limited relevant to that visit.  
 11:15 20 Even if they had another fracture, it's really not  
 11:16 21 relevant to that visit. What is relevant is their  
 11:16 22 current fracture, the state of the fracture and the  
 11:16 23 degree and where the fracture is located. And all  
 11:16 24 what would be relevant would be to know their

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11:16 1 general health, their allergy history, other  
 11:16 2 medical conditions that might impact on the  
 11:16 3 treatment that might be necessary, such as surgery,  
 11:16 4 things like that, but you would not go over their  
 11:16 5 entire medical history for something like that.

11:16 6 Q. And if a patient presented with pain in  
 11:16 7 various areas of their body, would that be  
 11:16 8 something that would require a review of the  
 11:16 9 medical records?

11:16 10 MR. LOMBARDO: I'm going to object to form,  
 11:16 11 incomplete hypothetical. You can answer to the  
 11:16 12 best of your ability, Doctor.

11:16 13 BY THE WITNESS:

11:16 14 A. Yes. Generally, if a patient had that  
 11:16 15 complaint, it would depend on a number of factors,  
 11:16 16 the specifics of when the -- am I being heard  
 11:17 17 because I'm not being shown. Can you hear me?

11:17 18 BY MS. REED:

11:17 19 Q. I can hear you, yes.

11:17 20 A. Oh, okay. It would depend on the  
 11:17 21 specifics of it, but, in general, yes, it would  
 11:17 22 require -- it should require a review of the record  
 11:17 23 as it pertains to that symptom and to look for  
 11:17 24 other visits that may have been similar.

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11:17 1 Q. Let's talk about the standards of care  
 11:17 2 for rheumatoid arthritis. Now in your prior  
 11:17 3 practice in internal medicine, did you have  
 11:18 4 experience with rheumatoid arthritis?

11:18 5 A. Patients with rheumatoid arthritis?

11:18 6 Q. Yes.

11:18 7 A. Yes.

11:18 8 Q. Okay. Did you ever diagnose somebody  
 11:18 9 with rheumatoid arthritis during your medical  
 11:18 10 practice?

11:18 11 A. Yes.

11:18 12 Q. How often roughly did you have to deal  
 11:18 13 with patients with rheumatoid arthritis?

11:18 14 A. Whenever it applied, whenever a patient  
 11:18 15 had the illness. So whenever I was taking care of  
 11:18 16 a patient and they had it, then I would deal with  
 11:18 17 it.

11:18 18 Q. Can you give me an estimate of the  
 11:18 19 percentage of your patients at your private  
 11:18 20 practice that had rheumatoid arthritis?

11:18 21 A. It's an uncommon illness. It would  
 11:18 22 affect just a few or 1 percent of the population  
 11:19 23 that I was taking care of, I would guess. Maybe  
 11:19 24 less than 1 percent. It's not a common illness.

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11:19 1 Q. When you had your private practice and  
 11:19 2 you came across a patient or diagnosed a patient  
 11:19 3 with rheumatoid arthritis, did you have to refer  
 11:19 4 them to a specialist or did you continue to treat  
 11:19 5 them for the rheumatoid arthritis?

11:19 6 A. I did not have to, no, and I did  
 11:19 7 continue -- I would continue to treat them.

11:19 8 Q. During your time at Wexford, did you  
 11:20 9 ever work solely as a physician at a site?

11:20 10 A. Yes.

11:20 11 Q. Okay. What was the time period in which  
 11:20 12 you did that?

11:20 13 A. From 1995 to 1998.

11:20 14 Q. Based on your review of the literature  
 11:20 15 on the standards of care for rheumatoid arthritis,  
 11:20 16 if someone were diagnosed with rheumatoid  
 11:20 17 arthritis, can you describe the treatment that you  
 11:20 18 would recommend?

11:21 19 A. It would depend on the patient-specific  
 11:21 20 circumstances, their findings as to what treatment  
 11:21 21 would be appropriate. There is no general  
 11:21 22 treatment or universal treatment that would be  
 11:21 23 appropriate to apply to all patients.

11:21 24 Q. What types of information do you need to

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11:21 1 get from the patient to determine the appropriate  
 11:21 2 treatment for rheumatoid arthritis?

11:21 3 A. Their history, their clinical findings,  
 11:21 4 their laboratory findings, X-ray findings, the  
 11:21 5 course of their illness, duration of their illness,  
 11:21 6 response to any treatments that have been provided  
 11:21 7 and adverse reactions perhaps to any treatments  
 11:21 8 that have been provided.

11:22 9 Family history has some relevance.

11:22 10 Comorbid illnesses, that is other illnesses that  
 11:22 11 the person may have that may impact on their  
 11:22 12 illness.

11:22 13 Q. Anything else?

11:22 14 A. The records. So that would include  
 11:22 15 evaluations that were done by other physicians,  
 11:22 16 their findings at the time. Sometimes family  
 11:22 17 members provide valuable information that augments  
 11:22 18 the patient's history. That is what comes to mind,  
 11:22 19 but what you are interested in is all information  
 11:22 20 that is relevant to that specific patient, and that  
 11:22 21 varies significantly. Some patients, because of a  
 11:23 22 stroke, are not able to speak, for example, so the  
 11:23 23 information is gathered from other sources,  
 11:23 24 relatives or records.

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11:23 1 But all information that is pertinent  
 11:23 2 and based upon something coming up that may open  
 11:23 3 the door for other information that -- that would  
 11:23 4 be accessed or be queried.

11:23 5 Q. Are you aware of particular medications  
 11:23 6 used to treat rheumatoid arthritis?

11:23 7 A. Yes.

11:23 8 Q. Okay. What are the ones that you are  
 11:23 9 aware of?

11:23 10 A. They primarily are a group of  
 11:24 11 medications called nonsteroidal antiinflammatory  
 11:24 12 agents. Also, acetaminophen, which is Tylenol.  
 11:24 13 Then there's another group of medications that  
 11:24 14 serve to depress the immune response of an  
 11:24 15 individual. Prednisone, methotrexate, and there is  
 11:24 16 a group of newer diseases, biologic agents, that  
 11:24 17 are also utilized and can be utilized in rheumatoid  
 11:24 18 arthritis.

11:24 19 So there are many agents that are  
 11:24 20 treated in a stepwise fashion. So we start with  
 11:24 21 medications that have the lower side effect risk  
 11:24 22 and profile, and based upon the specific findings  
 11:24 23 of the patient that is being treated, it would  
 11:25 24 dictate and determine which medications would be

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11:25 1 used.

11:25 2 Q. Are there any other treatment options  
 11:25 3 besides medication for rheumatoid arthritis?

11:25 4 A. Yes.

11:25 5 Q. Like what?

11:25 6 A. Affected joints can be injected with  
 11:25 7 cortisone. Other modalities are things like  
 11:25 8 bracing, splints, crutches or canes that are used  
 11:25 9 in ambulation. Physical therapy is sometimes used  
 11:25 10 in patients, again, individualized to a specific  
 11:25 11 patient. There are also other pain medications,  
 11:25 12 simple pain medication, narcotic medications or  
 11:25 13 narcotic-like medications, such as Tramadol that  
 11:26 14 are sometimes used and, again, limited to specific  
 11:26 15 patients and usually for limited periods of time.

11:26 16 Q. So for nonmedication treatments, you  
 11:26 17 listed a few things, such as cortisone, bracing  
 11:26 18 splints, physical therapy. Is there anything else  
 11:26 19 that you can think of that you have not talked  
 11:26 20 about?

11:26 21 A. Surgery might be used in cases where --  
 11:26 22 patients who have limited -- those extreme  
 11:26 23 deformities that -- for those few patients that  
 11:26 24 have an unfortunate severe case of rheumatoid



11:26 1 arthritis. You know, those would be the -- those  
 11:26 2 would be the modalities that are used.  
 11:26 3 Q. Are you familiar with the Rh factor?  
 11:27 4 A. I'm familiar with an Rh factor, yes.  
 11:27 5 Q. Okay. In your experience, in your  
 11:27 6 review of the literature, how is an Rh factor used  
 11:27 7 in coming to a diagnosis of rheumatoid arthritis?  
 11:27 8 A. So, first of all, Rh factor refers to a  
 11:27 9 blood antibody. That is -- the blood type is the  
 11:27 10 Rh. It's also used -- it's actually RA for  
 11:27 11 rheumatoid arthritis, but it is sometimes stated as  
 11:27 12 Rh. The question that you are asking is about the  
 11:27 13 rheumatoid factor, just to be clear. So rheumatoid  
 11:27 14 factor is -- your question, I'm sorry, is what?  
 11:27 15 You were asking about what?  
 11:27 16 Q. Yes. I can ask a better question this  
 11:27 17 time. How do you use the rheumatoid factor in  
 11:28 18 determining a diagnosis of rheumatoid arthritis?  
 11:28 19 A. It's one of the parameters that is  
 11:28 20 looked at in determining what a patient's condition  
 11:28 21 might be. So if a patient has symptoms that might  
 11:28 22 be caused by rheumatoid arthritis or a related  
 11:28 23 disease, that is a blood test that a clinician  
 11:28 24 would order and then interpret in the setting of

11:28 1 that patient.  
 11:28 2 Q. So aside from rheumatoid arthritis, when  
 11:28 3 might -- what other types of diseases would the  
 11:28 4 rheumatoid factor indicate?  
 11:28 5 A. The elevated, you mean?  
 11:28 6 Q. Yes, if it's elevated.  
 11:28 7 A. About 100 other diseases.  
 11:28 8 Q. Are those other diseases related to  
 11:28 9 rheumatoid arthritis, in your experience?  
 11:28 10 A. No. Most of them are not.  
 11:29 11 Q. Can you give me an example of some of  
 11:29 12 these other diseases?  
 11:29 13 A. Malignancies. So any cancer may give a  
 11:29 14 positive rheumatoid factor. Many inflammatory  
 11:29 15 illnesses, endocarditis is a characteristic disease  
 11:29 16 which will give a positive rheumatoid factor. But  
 11:29 17 any severe infection may give a positive rheumatoid  
 11:29 18 factor. And, again, hundreds of infections, and  
 11:29 19 there's hundreds of malignancies and any of those  
 11:29 20 could do that.  
 11:29 21 Now, it can also be found in a healthy  
 11:29 22 individual that has no identified illness. The  
 11:29 23 rheumatoid factor can be positive. And then,  
 11:29 24 conversely, it's maybe not positive in patients who

11:29 1 have known rheumatoid arthritis.  
 11:30 2 Q. You mentioned that a healthy patient  
 11:30 3 could have an elevated Rh factor. Do you know what  
 11:30 4 the percentage of healthy patients who have an  
 11:30 5 elevated Rh or rheumatoid factors is?  
 11:30 6 A. I don't believe that statistic is known  
 11:30 7 because people would not test that. It's not  
 11:30 8 indicated to test for people who are healthy, but  
 11:30 9 it is occasionally done, sometimes by mistake. And  
 11:30 10 then one looks at it and determines, finds out on  
 11:30 11 asking the person, that they don't have any joint  
 11:30 12 problems whatsoever, and nevertheless have a  
 11:30 13 positive number. I don't think that statistic is  
 11:30 14 known or could be known because, again, it would be  
 11:30 15 inappropriate to do that testing.  
 11:30 16 Q. Sure. In your experience, what types of  
 11:30 17 symptoms would cause you to test someone's  
 11:30 18 rheumatoid factor?  
 11:31 19 A. Specific joint complaints that are  
 11:31 20 characteristically seen in rheumatoid arthritis.  
 11:31 21 Q. Anything else?  
 11:31 22 A. Well, the joints involve the specifics  
 11:31 23 of that. That is, the time of the day, the  
 11:31 24 symptoms that they have, including things like

11:31 1 redness, inflammation, changes in the appearance of  
 11:31 2 their joints, specifically their hands. There's a  
 11:31 3 characteristic thing that happens to the joints and  
 11:31 4 that the fingers will deviate outwards or ulnar  
 11:31 5 deviation. Clinical findings consistent with  
 11:31 6 rheumatoid arthritis, such as rheumatoid nodules,  
 11:31 7 associated illnesses that may occur that are seen  
 11:32 8 in rheumatoid arthritis.  
 11:32 9 Laboratory -- somebody who may have  
 11:32 10 laboratory findings. Did you ask about symptoms  
 11:32 11 only or things in general that would provoke you to  
 11:32 12 test for that?  
 11:32 13 Q. My question was just about symptoms, but  
 11:32 14 you can expand it to general.  
 11:32 15 A. So the first things that I mentioned  
 11:32 16 would be -- the main thing would be the patient's  
 11:32 17 complaints of joint pain, specifically the joints  
 11:32 18 involved, the stiffness accompanying the pain.  
 11:32 19 Those symptoms would prompt me to consider  
 11:32 20 rheumatoid arthritis as a cause of the person's  
 11:32 21 joint pain.  
 11:32 22 Q. And once somebody presents with elevated  
 11:32 23 rheumatoid factors, what would be the next step in  
 11:32 24 your investigation to determine whether that person

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11:32 1 had rheumatoid arthritis?

11:32 2 A. Well, if a patient has an elevated

11:33 3 rheumatoid factor, that would be part of the

11:33 4 evaluation of that patient, along with all of the

11:33 5 other things that would be necessary in determining

11:33 6 the relevance of that finding, beginning with the

11:33 7 patient's history, starting when the patient's

11:33 8 symptoms started, the specifics of their symptoms.

11:33 9 Again, not just joint pain.

11:33 10 It varies according to what the cause

11:33 11 is, whether it's pain in their knees or in their

11:33 12 hands or where, whether it's one side or both

11:33 13 sides. All of those things make a difference, what

11:33 14 is associated with it, whether they have stiffness,

11:33 15 whether they have swelling of the joints.

11:33 16 Radiographic findings, and that would be dependent

11:33 17 on the course of their illness. Like somebody who

11:33 18 had symptoms early would unlikely have radiographic

11:34 19 findings, but somebody that had longstanding would

11:34 20 necessarily -- virtually necessarily have to have

11:34 21 radiographic findings. Other blood testing, signs

11:34 22 that are commonly associated with rheumatoid

11:34 23 arthritis, but also may indicate other illnesses.

11:34 24 For example, if a person, like I

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11:34 1 mentioned, had a rheumatoid factor and had

11:34 2 endocarditis, that would lead you to believe that

11:34 3 that was the cause of the elevated rheumatoid

11:34 4 factor. All of the information that I have

11:34 5 previously mentioned is necessary to -- to review

11:34 6 and to assimilate in determining the relevance of

11:34 7 the rheumatoid factor.

11:34 8 Q. In your experience, if someone has a

11:34 9 family history of rheumatoid arthritis, does that

11:35 10 make it more likely that they might also be

11:35 11 diagnosed with it?

11:35 12 A. Yes, it does run in family lines. It is

11:35 13 more likely, assuming the diagnosis is accurate.

11:35 14 It sometimes is not when a patient relays that

11:35 15 history because patients sometimes refer to

11:35 16 arthritis as rheumatism and confuse that with

11:35 17 rheumatoid arthritis, which is not the same thing.

11:35 18 So in my experience, I have had patients provide

11:35 19 that history incorrectly. Their family did not

11:35 20 actually have rheumatoid arthritis but actually had

11:35 21 rheumatism and confused the two terms.

11:35 22 Q. Switching back for a quick second to

11:35 23 your work as the regional director. Do your

11:35 24 physicians have a way to verify medical history

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11:35 1 that is outside of the prison? For example, if an

11:35 2 inmate comes in and talks about his prior treatment

11:36 3 before incarceration.

11:36 4 Do the physicians have access -- are

11:36 5 they able to go out and get those records from the

11:36 6 physicians outside of the prison?

11:36 7 A. They are not able to get them. They can

11:36 8 request them. The patient's consent is required,

11:36 9 and then he obviously has to have the information

11:36 10 as to where that care was provided. That often is

11:36 11 missing. They don't remember the doctor's name or

11:36 12 location, so there's no way of accessing it without

11:36 13 that information.

11:36 14 But if they have that information, then

11:36 15 a request for medical information can be sent, and

11:36 16 if the records are available and the provider

11:36 17 provides them, they can be sent.

11:36 18 Q. Okay. When you worked as a physician

11:36 19 between '95 and '98, do you have a recollection of

11:36 20 ever going out to get records on a patient that

11:37 21 were outside of the facility?

11:37 22 A. Yes, certainly.

11:37 23 Q. About how often did that occur when you

11:37 24 were a physician for Wexford?

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11:37 1 A. Whenever it was relevant for the

11:37 2 illness. And most of our patients are -- well,

11:37 3 people in prison are not there because they are

11:37 4 sick. They are there because they committed a

11:37 5 crime, so they are generally a healthy population

11:37 6 that usually does not have a serious illness for

11:37 7 which the records would be necessary, something

11:37 8 like cancer, surgery from previous illnesses, but

11:37 9 when that situation occurred, yes, records would be

11:37 10 requested.

11:37 11 But it would not be done on every

11:37 12 patient or where that information was unlikely to

11:37 13 yield anything of any benefit. It was not simply

11:37 14 done as an exercise because, again, it would not be

11:37 15 fruitful and it would just be a waste of time for

11:37 16 everyone.

11:37 17 Q. And so you have referred to several

11:38 18 different diseases as serious medical disease.

11:38 19 Would you classify rheumatoid arthritis as a

11:38 20 serious medical disease?

11:38 21 A. The spectrum varies greatly. That is,

11:38 22 somebody can have rheumatoid arthritis and no

11:38 23 active symptoms almost from the illness, and then

11:38 24 it can also be a very devastating, deforming

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11:38 1 illness that may put somebody as bedridden. So it  
11:38 2 can vary.

11:38 3 In some instances, it can -- it  
11:38 4 certainly is a serious illness. In other  
11:38 5 instances, it's not -- people have the illness, if  
11:38 6 they were -- and are not aware of it. They are  
11:38 7 attributing joint pains to something else, so they  
11:38 8 live a relatively normal life, being unaware of  
11:38 9 their illness. So it varies significantly. I  
11:38 10 would not say that -- certainly not that all  
11:38 11 patients with rheumatoid arthritis are -- that it's  
11:38 12 a serious illness in all patients.

11:39 13 MS. REED: Okay. I think now is a good time  
11:39 14 to take a break. Can we go off the record?

11:39 15 THE WITNESS: Sure.

11:39 16 (WHEREUPON, discussion was had off  
11:39 17 the record.)

11:54 18 BY MS. REED:

11:54 19 Q. Dr. Funk, do you understand that you are  
11:54 20 still under oath?

11:54 21 A. Yes.

11:54 22 Q. Okay. We'll proceed.

11:54 23 When we were talking earlier, you  
11:54 24 mentioned that you participate in the litigation

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11:56 1 A. Yes, if his -- if he was referenced and  
11:56 2 I received it, then yes.

11:56 3 Q. Well, let me ask that question again. I  
11:56 4 was saying e-mails between a physician and a site  
11:56 5 director, so not necessarily the e-mails to you as  
11:56 6 the regional medical director but the physician and  
11:56 7 the site director. Would those e-mails be  
11:56 8 encompassed in your litigation hold search?

11:56 9 A. Only if I was included in that. If I  
11:56 10 was not a part of that communication, then I would  
11:56 11 not. If I was included in it, then it would.

11:56 12 Q. Okay. Do you have a way to capture the  
11:56 13 e-mails that are not included, which reference the  
11:57 14 inmates?

11:57 15 A. I personally don't, no.

11:57 16 Q. But I assume the litigation hold would  
11:57 17 also go to the site director and the individual  
11:57 18 physicians involved with the inmate's treatment; is  
11:57 19 that correct?

11:57 20 A. Yes.

11:57 21 Q. Okay. And who makes sure that they  
11:57 22 preserve their e-mails with regards to the inmate?

11:57 23 A. Well, after they are sent to the risk  
11:57 24 management office, they preserve them. That is

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11:54 1 hold process --

11:55 2 A. Yes.

11:55 3 Q. -- for your region?

11:55 4 A. Well, I, as an employee, participate in  
11:55 5 it, yes.

11:55 6 Q. I'm sorry. Can you say that one more  
11:55 7 time?

11:55 8 A. Not just for my region. As an employee,  
11:55 9 when I am sent a litigation hold, I respond to it.

11:55 10 Q. Okay. Now, for the litigation hold for  
11:55 11 this case, do you recall when that started?

11:55 12 A. No.

11:55 13 Q. Okay. What types of documents would  
11:55 14 have been included in the litigation hold?

11:55 15 A. Any that pertain specifically to the  
11:55 16 patient, so any that would appear from the inmate  
11:55 17 number, the Department of Corrections inmate  
11:55 18 number, that is the number that is queried, that is  
11:55 19 used in communication to identify a person, and I  
11:55 20 put that number in and then do a search for that.

11:56 21 Q. Okay. Now, when you do this search,  
11:56 22 would that include, for example, you know, e-mails  
11:56 23 between physicians and their site directors which  
11:56 24 reference an inmate?

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11:57 1 their responsibility to preserve them.

11:57 2 Q. So if a litigation hold goes out to a  
11:57 3 number of physicians who are all involved with  
11:57 4 treatment of an inmate and one of those physicians  
11:57 5 does not respond, does risk management follow up  
11:58 6 with them to get their e-mails?

11:58 7 A. No. They are -- it would not be assumed  
11:58 8 that they have e-mails. That is sent to everyone.  
11:58 9 If they don't respond, it's assuming that they  
11:58 10 don't have -- they don't have anything to respond  
11:58 11 with, but they don't -- would not routinely, unless  
11:58 12 there was some reason to say, Well, you know, you  
11:58 13 have not responded because we don't respond with  
11:58 14 the negative or the fact that there is no  
11:58 15 information.

11:58 16 Q. Okay. In your experience as the  
11:58 17 regional medical -- as a regional medical director,  
11:58 18 are e-mails widely used to discuss treatment?

11:58 19 A. No.

11:58 20 Q. Okay. If a site director or physician  
11:59 21 would like your advice on a treatment strategy, how  
11:59 22 do they contact you?

11:59 23 A. By phone. Generally by phone.

11:59 24 Q. And if you need to review medical

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11:59 1 records in order to provide advice, how do you get  
 11:59 2 access to those medical records?  
 11:59 3 A. It would be from the physician relaying  
 11:59 4 them to me as part of the discussion. It would be  
 11:59 5 uncommon for me to review data. I would simply --  
 11:59 6 the conversation would include that information  
 11:59 7 that he would relay, so it would be an exchange and  
 11:59 8 I would talk to him and ask him what this showed or  
 11:59 9 that showed. But it's not effective to transmit  
 11:59 10 that type of -- that information electronically  
 11:59 11 because it's an exchange. I would ask questions  
 12:00 12 and he would respond to my questions, and he  
 12:00 13 wouldn't know necessarily what my question was to  
 12:00 14 be able to answer it in a written format. It would  
 12:00 15 be cumbersome and not productive.  
 12:00 16 Q. I agree. I wish you would tell that to  
 12:00 17 some of the partners that I work for.  
 12:00 18 A. I would be happy to.  
 12:00 19 Q. Now, in responding to the litigation  
 12:00 20 hold for this case, do you recall whether you had  
 12:00 21 e-mails with regards to the plaintiff?  
 12:00 22 A. No, I don't recall. I think he first  
 12:00 23 filed it in 2015, and that is when the litigation  
 12:00 24 hold would have been done. So it's five years ago.

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12:00 1 I don't remember.  
 12:00 2 Q. Okay.  
 12:00 3 A. Or seven years ago. I'm sorry.  
 12:00 4 Q. In preparation for this deposition, did  
 12:00 5 you go back and determine whether you had sent any  
 12:00 6 e-mails with regard to this plaintiff?  
 12:00 7 A. I generally do that. I don't recall if  
 12:00 8 I did it for this case. I may have done it, but I  
 12:01 9 don't recall. I generally do that just for my own  
 12:01 10 purpose, but I don't recall that I did or that I  
 12:01 11 didn't.  
 12:01 12 Q. Other than e-mails and patient records  
 12:01 13 and utilization management records and grievances,  
 12:01 14 are there any other types of documents that you  
 12:01 15 would expect to see as the result of a litigation  
 12:01 16 hold for someone like the plaintiff?  
 12:01 17 A. Well, I would not expect those records  
 12:01 18 that you mentioned in a litigation hold. I would  
 12:01 19 not expect to see medical records, grievances. I  
 12:01 20 would only expect correspondences specific to the  
 12:01 21 patient from a clinician or from some other person  
 12:02 22 in the system, but I would not expect all of those  
 12:02 23 documents. As a matter of fact, those documents  
 12:02 24 never occur.

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12:02 1 But to answer your question -- I'm sorry  
 12:02 2 again. What was your question?  
 12:02 3 Q. I was asking you if there were any other  
 12:02 4 types of records that you would expect to see as a  
 12:02 5 result of a litigation hold?  
 12:02 6 A. No. Just communications from a provider  
 12:02 7 or a site regarding the patient, some concern  
 12:02 8 regarding them, some event that had occurred.  
 12:02 9 Q. In preparation for the deposition, did  
 12:02 10 you ask risk management for all of their documents  
 12:02 11 that were being held as a result of the litigation  
 12:02 12 hold?  
 12:03 13 A. Not specifically, but I asked the  
 12:03 14 counsel for all of the documents relative to this  
 12:03 15 case, that he provide them to me and that would  
 12:03 16 include that. That has been the practice. I did  
 12:03 17 not specifically voice that, but I have done many  
 12:03 18 of these and it is that request that I always make  
 12:03 19 to the attorneys representing these claims. And  
 12:03 20 that would include that information certainly.  
 12:03 21 Q. Okay. When you reviewed the records in  
 12:03 22 preparation for this deposition, was there anything  
 12:03 23 that you did not receive that you would have liked  
 12:03 24 to have in order to prepare?

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12:03 1 A. The unknown, you mean? I don't know  
 12:03 2 what I didn't receive. I only know what I did  
 12:03 3 receive. There is nothing that I was expecting to  
 12:03 4 have received that I did not receive.  
 12:03 5 Q. Okay. I want to switch gears a little  
 12:04 6 bit. Have you met the plaintiff, Jovan Daniels?  
 12:04 7 A. Not that I'm aware of.  
 12:04 8 Q. Okay. And I'm just going to ask you  
 12:04 9 about various parties and people or entities  
 12:04 10 involved in the case and ask you about your  
 12:04 11 familiarity.  
 12:04 12 A. Yes.  
 12:04 13 Q. So the late Dr. Saleh Obaisi --  
 12:04 14 A. Obaisi, yes.  
 12:04 15 Q. -- Obaisi. Were you familiar with him?  
 12:04 16 A. Yes, very familiar.  
 12:04 17 Q. And can you describe for me your  
 12:04 18 relationship?  
 12:04 19 A. I was his supervisor. He was a medical  
 12:04 20 director. I was his direct supervisor.  
 12:05 21 Q. So based on what we talked about  
 12:05 22 earlier, you would have participated in his annual  
 12:05 23 reviews; is that correct?  
 12:05 24 A. Yes.

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12:05 1 Q. Okay. And are those reviews documented  
 12:05 2 somewhere within the company?  
 12:05 3 A. I have seen written -- I have seen some  
 12:05 4 that were written, yes. I'm not sure that they are  
 12:05 5 always done written and in a written format, but I  
 12:05 6 have seen some that were in writing.  
 12:05 7 Q. Let me ask my question another way.  
 12:05 8 When you reviewed Dr. Obaisi, did you have to fill  
 12:05 9 out a form for the annual review? Just to clarify.  
 12:05 10 A. We at one time did. Then the  
 12:05 11 responsibility was shifted to the regional manager  
 12:05 12 and that transition occurred, oh, probably eight or  
 12:06 13 nine years ago, when the responsibility of the  
 12:06 14 annual review was delegated to the regional  
 12:06 15 manager. Prior to that, it was a written  
 12:06 16 evaluation that was done that I would have done.  
 12:06 17 Q. Okay. And aside from being Dr. Obaisi's  
 12:06 18 supervisor, did you have any other relationship  
 12:06 19 outside of work with him?  
 12:06 20 A. No.  
 12:06 21 Q. And based on your familiarity from  
 12:06 22 reviewing and supervising Dr. Obaisi, was there  
 12:06 23 ever any corrective actions issued with regards to  
 12:06 24 his decisions?

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12:06 1 A. There was one incident I recall that had  
 12:07 2 to do with his documentation that took place during  
 12:07 3 the time that I was his supervisor.  
 12:07 4 Q. Sorry. Could you repeat that last part  
 12:07 5 one more time?  
 12:07 6 A. During the time that I was his  
 12:07 7 supervisor, there was one incident that I'm aware  
 12:07 8 of.  
 12:07 9 Q. Okay. Did you know Dr. Obaisi prior to  
 12:07 10 the time that you became his supervisor?  
 12:07 11 A. Yes.  
 12:07 12 Q. And during that time, do you know of any  
 12:07 13 corrective actions that were issued to him?  
 12:07 14 A. There was an incident that occurred when  
 12:07 15 he was at another site that I was not supervising  
 12:07 16 that I became aware of somehow, and I don't  
 12:07 17 remember how it was. But that I became aware of,  
 12:08 18 but it was not clinical. It did not have anything  
 12:08 19 to do with clinical -- it was not a clinical matter  
 12:08 20 or a patient matter.  
 12:08 21 Q. Other than the two corrective actions  
 12:08 22 that we have talked about, are you aware of any  
 12:08 23 other corrective actions issued to Dr. Obaisi?  
 12:08 24 A. No, not that I'm aware of.

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12:08 1 Q. Did you hire Dr. Obaisi?  
 12:08 2 A. I don't recall if I was involved with  
 12:08 3 his hiring or not. He had worked for the company  
 12:08 4 for many years. I don't recall my involvement with  
 12:08 5 his hiring.  
 12:08 6 Q. Do you recall any involvement with his  
 12:09 7 training?  
 12:09 8 A. No. He had been working for Wexford  
 12:09 9 prior to my becoming his supervisor for a number of  
 12:09 10 years, so I would not have been involved.  
 12:09 11 Q. Okay. In your supervision of  
 12:09 12 Dr. Obaisi, can you think of a time where you  
 12:09 13 disagreed with the diagnosis that he made?  
 12:09 14 A. I can't recall a specific time, but  
 12:09 15 physicians often disagree on diagnoses. That is a  
 12:09 16 very common -- when we render an opinion, but I  
 12:09 17 don't recall a specific instance or an adverse  
 12:10 18 result as to our difference that may have occurred.  
 12:10 19 Again, I don't recall, but, again, it's  
 12:10 20 very common that -- physicians are required to use  
 12:10 21 their own judgment. And in that, that judgment  
 12:10 22 will differ, and it's not -- it's not unusual to  
 12:10 23 have a difference in a diagnosis.  
 12:10 24 Q. Similar to lawyers. We disagree about

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12:10 1 how to do things.  
 12:10 2 A. Yes. Right, right.  
 12:10 3 Q. Have you reviewed Dr. Obaisi's progress  
 12:10 4 notes for the plaintiff?  
 12:10 5 A. Yes. I reviewed the records, and I  
 12:10 6 would have reviewed his notes, yes.  
 12:10 7 Q. As you sit here today, do you recall  
 12:10 8 anything that you disagreed with, any  
 12:11 9 recommendations that he wrote in his progress notes  
 12:11 10 that you disagreed with?  
 12:11 11 A. That I disagreed with him offering at  
 12:11 12 the time or my opinion of what his -- what the  
 12:11 13 diagnosis was or the impression was of the  
 12:11 14 patient's condition? Those are two different  
 12:11 15 things.  
 12:11 16 Q. Let's start with the latter.  
 12:11 17 A. I don't know -- I don't recall  
 12:11 18 specifically if his impression was that the patient  
 12:11 19 had rheumatoid arthritis. I know it was a  
 12:11 20 consideration. I don't recall, and I did not  
 12:11 21 really review that with that in mind. But if his  
 12:12 22 impression was that he had rheumatoid arthritis,  
 12:12 23 and it may have been, I would disagree with that.  
 12:12 24 My impression is that the patient does not have



12:12 1 rheumatoid arthritis.  
 12:12 2 Now, whether that opinion would have  
 12:12 3 been done contemporaneously, I don't know. I have  
 12:12 4 the benefit of retrospect and knowing things that  
 12:12 5 Dr. Obaisi didn't. That is, the fact that he did  
 12:12 6 not improve with the treatment and subsequent --  
 12:12 7 his subsequent course and opinion -- other findings  
 12:12 8 of physicians that had seen him years later, so I  
 12:12 9 have a completely different perspective than  
 12:12 10 Dr. Obaisi had. But my opinion is -- it would be  
 12:12 11 different if Dr. Obaisi felt he had rheumatoid  
 12:12 12 arthritis.

12:12 13 Q. Okay. So can you give me a little more  
 12:13 14 detail about why, if you -- let me strike that.

12:13 15 Assuming for the purposes of this  
 12:13 16 question that Dr. Obaisi believed that the  
 12:13 17 plaintiff had rheumatoid arthritis. Are you saying  
 12:13 18 now that you would disagree with that assessment?  
 12:13 19 I guess I'm just trying to make sure what your  
 12:13 20 disagreement is.

12:13 21 A. Yes, I would disagree with that, if that  
 12:13 22 was, in fact, his assessment, which I'm not saying  
 12:13 23 that it was. I don't know. He did refer him to a  
 12:13 24 rheumatologist, but that does not mean that he

12:13 1 believed that. People refer -- doctors refer  
 12:14 2 patients for opinions, and that does not mean that  
 12:14 3 he was in belief but he certainly considered it as  
 12:14 4 a cause of his symptoms.

12:14 5 Q. And why do you think that the plaintiff  
 12:14 6 does not have rheumatoid arthritis?

12:14 7 A. For a number of reasons. The clinical  
 12:14 8 picture does not fit rheumatoid arthritis. The  
 12:14 9 only thing is that he has a slight elevation in  
 12:14 10 rheumatoid -- in his rheumatoid factor. He  
 12:14 11 characterizes it as out of range. It's not out of  
 12:14 12 range. It's in range, but it's beyond what is  
 12:14 13 typically seen in a healthy person.

12:14 14 But his history does not fit rheumatoid  
 12:14 15 arthritis. His laboratory parameters do not fit  
 12:14 16 rheumatoid arthritis. His clinical course does not  
 12:14 17 fit rheumatoid arthritis. His lack of response to  
 12:15 18 methotrexate -- well, I would say actually his  
 12:15 19 symptoms, from my review of the record, actually  
 12:15 20 worsened after he was given methotrexate. The lack  
 12:15 21 of radiographic findings and the duration of time  
 12:15 22 that he has had an abnormal rheumatoid factor, an  
 12:15 23 elevated rheumatoid factor is not consistent with  
 12:15 24 rheumatoid arthritis.

12:15 1 His current most recent findings by the  
 12:15 2 physician that he saw in the Cook County system,  
 12:15 3 his documentation of his symptoms, his findings,  
 12:15 4 and also it was -- although I did not see it, I  
 12:15 5 just got the records yesterday afternoon, but it  
 12:15 6 was stated by the physician that his rheumatoid  
 12:15 7 factor was negative in the note.

12:15 8 I looked for that and I could not find  
 12:15 9 the actual report, but it is stated in the last  
 12:16 10 visit, recognizing that he had previously had, by  
 12:16 11 his history, an elevated rheumatoid factor, and he  
 12:16 12 had mentioned that the rheumatoid factor was  
 12:16 13 negative.

12:16 14 So those things -- so the whole thing  
 12:16 15 together all speaks against rheumatoid arthritis as  
 12:16 16 being a reasonable disease for Mr. Daniels.

12:16 17 Q. Okay. I'm going to dig into some of  
 12:16 18 those -- the things that you listed.

12:16 19 A. Yes.

12:16 20 Q. So one of the things that you talked  
 12:16 21 about is his rheumatoid factor levels, and my  
 12:16 22 understanding of what you said -- and correct me if  
 12:16 23 I'm wrong -- is that his levels were only slightly  
 12:17 24 elevated?

12:17 1 A. Yes.

12:17 2 Q. Okay. And so why does that to you  
 12:17 3 indicate that he did not have rheumatoid arthritis?

12:17 4 A. There is a correlation with the degree  
 12:17 5 of the titer. That is, how highest it's elevated  
 12:17 6 and the likelihood of the patient having the  
 12:17 7 illness as opposed to it being caused by another  
 12:17 8 condition or by no condition at all. So he is in  
 12:17 9 the range where it's not significantly elevated,  
 12:17 10 and that would be defined as less than three times  
 12:17 11 the upper limit of normal.

12:17 12 Q. And you mention that his history also  
 12:17 13 causes you to believe that he does not have  
 12:18 14 rheumatoid arthritis. What about his history  
 12:18 15 supports your conclusion?

12:18 16 A. Well, I also mentioned -- I think you  
 12:18 17 missed this. I mentioned the other factors that  
 12:18 18 were not present, other laboratory factors that  
 12:18 19 were not present, typically seen in rheumatoid  
 12:18 20 arthritis. I just want to clarify that it's not  
 12:18 21 simply the rheumatoid factor in him that was looked  
 12:18 22 at, but the absence of other laboratory parameters  
 12:18 23 that are characteristically seen in rheumatoid  
 12:18 24 arthritis were not present in Mr. Daniels.



12:18 1 Q. That was my next thing on the list.  
 12:18 2 A. I'm sorry.  
 12:18 3 Q. That's okay, but that makes sense to  
 12:18 4 talk about it now. So there was an absence of  
 12:18 5 other factors that would typically indicate  
 12:18 6 rheumatoid arthritis; is that what you are saying?  
 12:18 7 A. Laboratory. Specifically laboratory.  
 12:18 8 Also, radiographic X-ray but specifically  
 12:18 9 laboratory were absent.  
 12:18 10 Q. So what laboratory factors would you  
 12:18 11 expect to be present if someone had rheumatoid  
 12:19 12 arthritis?  
 12:19 13 A. They are inflammatory markers, something  
 12:19 14 called a sed rate. It's abbreviated ESR. Another  
 12:19 15 parameter, I don't remember if they mentioned it  
 12:19 16 was measured, but something called C reactive  
 12:19 17 protein.  
 12:19 18 Those numbers are inflammatory markers  
 12:19 19 and are usually very elevated, reliably very  
 12:19 20 elevated, and inflammatory conditions, such as  
 12:19 21 rheumatoid arthritis, when someone has rheumatoid  
 12:19 22 arthritis, active rheumatoid arthritis. I know his  
 12:19 23 sed rate was consistently very low, which is just  
 12:19 24 not consistent with rheumatoid arthritis. I don't

12:19 1 recall what his C reactive protein was.  
 12:19 2 There's another antibody called anti-CCP  
 12:19 3 that is characteristically seen in rheumatoid  
 12:19 4 arthritis as a positive. He was negative. Other  
 12:20 5 things that are commonly seen are results in  
 12:20 6 inflammation resulting in anemia, specifically a  
 12:20 7 type of anemia called anemia of chronic disease.  
 12:20 8 He was not anemic and depressed protein, as another  
 12:20 9 phenomenon that occurs in people who have  
 12:20 10 inflammatory diseases, such as rheumatoid  
 12:20 11 arthritis, and specifically albumin will be  
 12:20 12 depressed. He did not have a depressed albumin.  
 12:20 13 So of the many laboratory things that I  
 12:20 14 looked at, he only had one, and that was only a  
 12:20 15 weekly positive finding.  
 12:20 16 Q. The other laboratory factors that you  
 12:20 17 just named, were you looking at the results from  
 12:20 18 the time that he was incarcerated, or are you  
 12:20 19 referring -- I guess I just want the time period.  
 12:20 20 A. I looked at every record, every page, so  
 12:21 21 that was the 15 years that he -- 12 years. 2005 to  
 12:21 22 2017, I think, when he was released. I looked at  
 12:21 23 all of those records and also the records that were  
 12:21 24 just provided yesterday afternoon, but I just

12:21 1 scanned through them. I did not have time to look  
 12:21 2 at them very carefully.  
 12:21 3 Q. Okay. So it's your testimony that the  
 12:21 4 inflammatory factors that you would typically  
 12:21 5 expect to be elevated were not for the plaintiff?  
 12:21 6 A. Markers, yes. Inflammatory markers were  
 12:21 7 absent, yes.  
 12:21 8 Q. Okay. Now switching back to the  
 12:21 9 history, what about the plaintiff's history causes  
 12:21 10 you or adds to your conclusion that he does not  
 12:22 11 have rheumatoid arthritis?  
 12:22 12 A. His history being inconsistent with the  
 12:22 13 history of somebody who has rheumatoid arthritis  
 12:22 14 and him having an explanation -- other explanations  
 12:22 15 for what his symptoms might be attributable to.  
 12:22 16 Q. Okay. What would you expect from a  
 12:22 17 person who does have rheumatoid arthritis?  
 12:22 18 A. They typically will have symmetrical  
 12:22 19 pain and stiffness. They will complain of the two.  
 12:22 20 Their hands are almost always involved, and because  
 12:22 21 of the use of the hands, it becomes a complaint  
 12:22 22 that people have and it will be consistent that  
 12:22 23 they will have stiffness and pain of the joints of  
 12:22 24 the hand, particularly the MTP joints, metatarsal

12:23 1 phalangeal joints, the knuckles of the hands and  
 12:23 2 then lesser to the fingers, the PIP joints and of  
 12:23 3 the wrist.  
 12:23 4 They will characteristically have early  
 12:23 5 morning stiffness and pain. Grasping will be  
 12:23 6 painful, and they may have weakness. That is  
 12:23 7 another complaint that is characteristic of people  
 12:23 8 who have rheumatoid arthritis. It rarely affects  
 12:23 9 the joints he complained about, his back and elbow.  
 12:23 10 It does sometimes, but it was just one elbow.  
 12:23 11 And his complaints, when he complained  
 12:23 12 of joint pain, were infrequent relative to his  
 12:23 13 other complaints, and they were not typical of  
 12:23 14 somebody who is a rheumatoid patient.  
 12:23 15 Q. You also mentioned his clinical courses?  
 12:24 16 A. Clinical course, yes.  
 12:24 17 Q. Sorry. One more time?  
 12:24 18 A. Clinical course.  
 12:24 19 Q. Clinical course is one of the things  
 12:24 20 that you considered in forming your opinion that he  
 12:24 21 does not have rheumatoid arthritis. What about the  
 12:24 22 clinical course contributes to your opinion?  
 12:24 23 A. So a patient who has especially  
 12:24 24 untreated rheumatoid arthritis, that is without an

12:24 1 immunosuppressive agent, their illness would be  
 12:24 2 expected to progress, and that would show -- result  
 12:24 3 in clinical findings that the disease worsens and  
 12:24 4 radiographic and laboratory findings.  
 12:24 5       So all of those things should expand  
 12:24 6 over time, amplify over time. So having the  
 12:24 7 benefit of looking retrospectively at what occurred  
 12:25 8 and currently what his status is, he does not have  
 12:25 9 findings, even in the present day, after having had  
 12:25 10 this elevated rheumatoid factor for, what, at least  
 12:25 11 10 or 15 years. So that is, again, completely  
 12:25 12 inconsistent with it being a diagnosis of  
 12:25 13 rheumatoid arthritis, and especially in the face of  
 12:25 14 him not being on any immunosuppressive agent which  
 12:25 15 could have slowed down the progression of the  
 12:25 16 illness.  
 12:25 17       In addition, when he was -- except for  
 12:25 18 that short period of time, three months or so. And  
 12:25 19 then during the time when he was on a medication  
 12:25 20 for which symptoms would be expected to resolve or  
 12:25 21 mitigate, his symptoms actually amplified. He  
 12:25 22 complained more about joint pain during the time he  
 12:25 23 was treated with the agent which is used to reduce  
 12:26 24 the symptoms of rheumatoid arthritis, and he even

12:26 1 acknowledged that in his subsequent notes, that it  
 12:26 2 was ineffective.  
 12:26 3       Q. What is the agent that is used to reduce  
 12:26 4 the symptoms of rheumatoid arthritis?  
 12:26 5       A. Well, the immunosuppressive agent that I  
 12:26 6 was referring to was methotrexate.  
 12:26 7       Q. Okay. Now, I think that moves us on to  
 12:26 8 our next one, lack of response to the methotrexate.  
 12:26 9 What response would you have expected to see?  
 12:26 10       A. Well, from reviewing the record, he  
 12:26 11 didn't have a diminution in his joint pain that  
 12:27 12 would have been expected to have occurred. So  
 12:27 13 either there would have been no improvement but  
 12:27 14 likely there should have been an improvement. But  
 12:27 15 what actually happened was, there was an increase  
 12:27 16 in his complaints of joint pain that occurred  
 12:27 17 during the time that he was receiving the  
 12:27 18 treatment, which, again, is completely inconsistent  
 12:27 19 with rheumatoid as a diagnosis.  
 12:27 20       Q. Then in the Cook County documents, you  
 12:27 21 mentioned that the -- there was a negative  
 12:27 22 rheumatoid factor?  
 12:27 23       A. I mentioned it was in the note of the  
 12:27 24 physician that there was a negative rheumatoid

12:27 1 factor. I did not actually see the result. I  
 12:27 2 could not find -- even though there was some --  
 12:28 3 laboratory results were submitted, I did not see  
 12:28 4 it. But, again, I did not have much time to look  
 12:28 5 at it.  
 12:28 6       It's actually -- the last sentence of  
 12:28 7 the last visit states that rheumatoid factor is  
 12:28 8 negative, and it acknowledges that it had been  
 12:28 9 positive.  
 12:28 10       Q. The fact that it was -- or that there's  
 12:28 11 a progress note talking about the rheumatoid factor  
 12:28 12 being negative, how does that factor contribute to  
 12:28 13 your opinion?  
 12:28 14       A. It just strengthens it. I would not  
 12:28 15 change it. I would not expect that it would be  
 12:28 16 negative. That surprises me a little bit, but it  
 12:28 17 does not alter my opinion. It would, if anything,  
 12:28 18 just strengthen it, but it doesn't change it.  
 12:28 19       Q. Why does it surprise you?  
 12:28 20       A. Generally, if it was positive for the  
 12:28 21 length of time that it was, from the lab reports  
 12:28 22 that I had seen, whatever is causing it to be  
 12:28 23 elevated, I believe, is still there. He's the same  
 12:29 24 biologic person, and then whatever -- it generally

12:29 1 does not just disappear. It is present in some  
 12:29 2 individuals and it's unexplained. I mean, it's  
 12:29 3 associated with certain illnesses, but in some  
 12:29 4 people it's just present and it's not known why,  
 12:29 5 but they generally have it. It does fluctuate, as  
 12:29 6 it did in this case, but it usually does not become  
 12:29 7 negative once it's elevated.  
 12:29 8       Q. In your experience, are there certain  
 12:29 9 environmental factors that could cause someone to  
 12:29 10 develop rheumatoid arthritis?  
 12:29 11       A. No. Not external environmental factors,  
 12:29 12 no.  
 12:29 13       Q. Okay. Was there anything else about the  
 12:29 14 clinical picture, other than the things that we  
 12:29 15 just talked about, that contributed to your opinion  
 12:29 16 about the diagnosis of rheumatoid arthritis?  
 12:30 17       A. I mentioned -- I'm sure I mentioned the  
 12:30 18 findings of the physicians and their opinion of  
 12:30 19 those that had seen him recently, subsequent to his  
 12:30 20 parole or release from prison, what their findings  
 12:30 21 were and opinion about his -- what the cause of his  
 12:30 22 symptoms were. That also played a role in my  
 12:30 23 opinion.  
 12:30 24       Q. Okay.

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12:30 1 A. Another thing I would say is, what also  
 12:30 2 moved my opinion was Mr. Daniels' deposition, where  
 12:30 3 what he stated was, when he was asked why he was  
 12:30 4 filing a lawsuit, he stated because he had an  
 12:30 5 elevated rheumatoid factor and it appeared to me  
 12:30 6 that he -- his belief has been influenced by that  
 12:31 7 laboratory result as patients sometimes are. They  
 12:31 8 believe they have the disease because they have  
 12:31 9 this laboratory finding, which is often seen in the  
 12:31 10 disease, and they attribute or believe they have  
 12:31 11 the disease.

12:31 12 So his belief is that he has the  
 12:31 13 illness, and, therefore, may attribute some of his  
 12:31 14 symptoms or suggest that some of his symptoms may  
 12:31 15 be related to that and that that seemed to happen,  
 12:31 16 from the interview with the rheumatologist, where  
 12:31 17 he had asked him some questions of rheumatoid  
 12:31 18 symptoms that he responded to but were not actually  
 12:31 19 elicited by Mr. Daniels over the many years he had  
 12:31 20 seen providers in the prison system.

12:31 21 So I believe he's been -- it was  
 12:32 22 suggested to him or he believes that he has the  
 12:32 23 illness, and, therefore, some of those symptoms  
 12:32 24 that he's relating are things that he believes

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12:34 1 have rheumatoid levels that are not significantly  
 12:34 2 elevated but they still, in your belief, possess  
 12:34 3 the disease?

12:34 4 A. That can exist, yes. Again, it's looked  
 12:34 5 at as one of the parameters in making that  
 12:34 6 judgment. It would be inappropriate to make a  
 12:34 7 determination solely defined on their rheumatoid  
 12:34 8 factor or their level.

12:34 9 Q. Okay. I'm going to go back to the  
 12:35 10 various employees. Are you familiar with a Paul or  
 12:35 11 a Dr. Paul Williams?

12:35 12 A. No.

12:35 13 Q. Okay. Are you familiar with a  
 12:35 14 Dr. Adrian Feinerman?

12:35 15 A. Yes.

12:35 16 Q. Okay. What is your familiarity with  
 12:35 17 Dr. Feinerman?

12:35 18 A. He was a medical director at a facility  
 12:35 19 that I did not supervise, but I knew of him from  
 12:35 20 meetings that we had. I knew he was the medical  
 12:35 21 director there.

12:35 22 Q. Okay. Is he still the medical director?

12:35 23 A. No.

12:35 24 Q. Okay.

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12:32 1 would be consistent with that or his judgment has  
 12:32 2 been prejudiced by the laboratory data that he has.

12:32 3 Q. A few follow-up questions. Does  
 12:32 4 methotrexate impact your rheumatoid levels at all?

12:32 5 A. It may. It may actually depress the  
 12:32 6 level. It's -- again, that is not the purpose of  
 12:32 7 the medication, but it may reduce the titer of the  
 12:32 8 rheumatoid factor.

12:33 9 Q. And in your experience, have you ever  
 12:33 10 seen patients who did not have the typical  
 12:33 11 inflammatory markers but in your belief did have  
 12:33 12 rheumatoid arthritis?

12:33 13 A. Yes. The disease can -- has a wide  
 12:33 14 range in its presentation, but characteristically  
 12:33 15 those are the findings that you would -- that were  
 12:33 16 discussed. Those are the findings that you expect  
 12:33 17 to see.

12:33 18 There are patients who have inactive  
 12:33 19 disease that may have rheumatoid arthritis but not  
 12:33 20 have an active form or the manifestations of that.  
 12:33 21 That does exist, but the common presentation is the  
 12:33 22 person that has those other findings.

12:33 23 Q. And in your experience as a physician  
 12:34 24 and medical director, have you seen patients who

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12:35 1 A. I believe he -- he may have passed, but  
 12:35 2 I'm not -- I heard he had a stroke, but that was  
 12:36 3 years ago.

12:36 4 Q. Okay. What about a Dr. John R.  
 12:36 5 Shepherd?

12:36 6 A. Yes.

12:36 7 Q. And how are you familiar with  
 12:36 8 Dr. Shepherd?

12:36 9 A. He was a doctor that I had met at  
 12:36 10 company meetings. He was a physician that worked  
 12:36 11 at other facilities but not that I was direct  
 12:36 12 supervisor of.

12:36 13 Q. Okay. What about Rashida Pollion?

12:36 14 A. Spell that, please. What is the last  
 12:36 15 name?

12:36 16 Q. P-o-l-l-i-o-n.

12:36 17 A. I don't know that person. I don't  
 12:36 18 believe -- it's probably a nurse, but I don't think  
 12:36 19 that I know that person.

12:36 20 Q. Okay. And does your supervisory duties  
 12:37 21 include supervising nurses?

12:37 22 A. Not directly, no.

12:37 23 Q. What about Mikhail Magdel?

12:37 24 A. Dr. Magdel, yes, I do know him.

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12:37 1 Q. And what is your familiarity with  
 12:37 2 Dr. Magdel?  
 12:37 3 A. He was a -- I know I interviewed him,  
 12:37 4 and I know he had worked as a physician for a  
 12:37 5 number of years, but not at a facility that I  
 12:37 6 supervised.  
 12:37 7 Q. What about Kimberly Criss, C-r-i-s-s?  
 12:37 8 A. I don't personally know that individual.  
 12:37 9 Q. Okay. What about LaTonya Williams?  
 12:37 10 A. I do know LaTonya Williams. She's a  
 12:37 11 physician assistant at Stateville or was.  
 12:37 12 Q. Okay. And do you have any supervisory  
 12:37 13 duties with respect to LaTonya?  
 12:37 14 A. Not directly. It would be a facility in  
 12:38 15 my district, but I would not be her direct  
 12:38 16 supervisor. The site medical director would be.  
 12:38 17 Q. With regards to nurses in your  
 12:38 18 facilities, if there was a corrective action  
 12:38 19 issued, would you have been notified?  
 12:38 20 A. Depending on the subject matter. I may  
 12:38 21 have, but, generally, no, I would not. For minor  
 12:38 22 issues, I would not be involved with that.  
 12:38 23 Q. Okay. Are you aware of any corrective  
 12:38 24 actions issued to Ms. Williams?

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12:38 1 A. I believe that there was for attendance.  
 12:38 2 She was coming late. I'm certain there was. I  
 12:38 3 know there was some matter or issue relating to her  
 12:39 4 coming late in the morning, arriving late at work.  
 12:39 5 Q. Anything else?  
 12:39 6 A. That's all I recall.  
 12:39 7 Q. How about Dr. Liping Zhang?  
 12:39 8 A. She was a physician at the facility, at  
 12:39 9 Stateville.  
 12:39 10 Q. And did you supervise Dr. Zhang?  
 12:39 11 A. No, not directly.  
 12:39 12 Q. Okay. Do you recall there being any  
 12:39 13 corrective actions against Dr. Zhang?  
 12:39 14 A. Yes.  
 12:39 15 Q. Okay. For what?  
 12:39 16 A. I recall a clinical matter for which she  
 12:39 17 was disciplined and possibly terminated, and I  
 12:40 18 don't recall if she was disciplined and then  
 12:40 19 resigned or she was actually terminated.  
 12:40 20 Q. Do you recall what the circumstances of  
 12:40 21 that clinical matter were?  
 12:40 22 A. Not the details of it. It was -- this  
 12:40 23 would have been about seven or eight years ago,  
 12:40 24 maybe longer, so I don't remember specifically.

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12:40 1 Q. Is there a limit on corrective actions  
 12:40 2 that you can receive before you are terminated?  
 12:40 3 A. The number?  
 12:40 4 Q. Yes.  
 12:40 5 A. No, it's a progressive discipline. So  
 12:40 6 it progresses, depending on what the matter is, and  
 12:40 7 it progresses to termination, if that is indicated.  
 12:41 8 Q. Okay. What about Dr. Fe Poblete  
 12:41 9 Fuentes?  
 12:41 10 A. Dr. Fuentes. I am aware of her. She  
 12:41 11 was at a facility, Menard, that is not in my  
 12:41 12 district. I was aware of her as a physician at the  
 12:41 13 facility, but that is all.  
 12:41 14 Q. Okay. What about Dr. Samuel Nwaobasi?  
 12:41 15 A. Again, I know of him as a physician at  
 12:41 16 Menard, which is a facility that I did not  
 12:41 17 supervise, so I don't have direct -- did not have  
 12:41 18 direct involvement with him. I just knew of his  
 12:41 19 presence or employment with Wexford in that  
 12:41 20 capacity.  
 12:41 21 Q. What region is Menard in?  
 12:41 22 A. Southern. Southern part of the state.  
 12:41 23 Q. Okay. Who is the supervising person for  
 12:42 24 that region?

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12:42 1 A. Presently, it's Dr. Glen Babich,  
 12:42 2 B-a-b-i-c-h.  
 12:42 3 Q. Okay.  
 12:42 4 A. But at the time, it would have been  
 12:42 5 somebody -- he has been in prison for a long time,  
 12:42 6 so up until two years ago, we had two regional  
 12:42 7 medical directors. The state was divided north and  
 12:42 8 south. The southern would have been Dr. Rob  
 12:42 9 Matticks, M-a-t-t-i-c-k-s, and Menard would have  
 12:42 10 been in his district. Two years ago a third  
 12:42 11 regional medical director was added, and we divided  
 12:42 12 the state from two into three.  
 12:42 13 Q. Did you ever work in the southern region  
 12:42 14 during your time at Wexford?  
 12:42 15 A. No. No, I never worked in the southern  
 12:42 16 region, but there was also a time between regional  
 12:43 17 medical directors, where I was the only regional  
 12:43 18 medical director. That was only about, I think,  
 12:43 19 maybe six months or so, until they hired the second  
 12:43 20 regional medical director, or the one -- the  
 12:43 21 previous one had left, and I was the only one for  
 12:43 22 about six months.  
 12:43 23 Q. Do you recall about when that was?  
 12:43 24 A. It would have been about early 2000s,

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12:43 1 like 2008, I think. 2008, 2009, I'm guessing,  
 12:43 2 around there.  
 12:43 3 Q. Is it fair to say that the various  
 12:43 4 regions are all governed by the same guidelines in  
 12:43 5 Illinois?  
 12:43 6 A. Yes. Yes. Individual facilities have  
 12:44 7 individual makeups, so they have different  
 12:44 8 missions, but generally that statement is true.  
 12:44 9 Q. Okay. So let me ask a better question.  
 12:44 10 So for Stateville, for example, is there a written  
 12:44 11 set of guidelines that Wexford employees would  
 12:44 12 refer to or look at?  
 12:44 13 A. Yes. So it's Stateville. There's no  
 12:44 14 second S, but everyone thinks there is. Yes, there  
 12:44 15 are -- there are guidelines that apply to the  
 12:44 16 entire state, and then each site will have specific  
 12:44 17 guidelines for its specific needs.  
 12:44 18 Q. Okay. Are you familiar with a  
 12:45 19 Dr. Robert Shaefer?  
 12:45 20 A. Yes.  
 12:45 21 Q. Okay. And --  
 12:45 22 A. It's Ronald. Ronald Shaefer, it should  
 12:45 23 be.  
 12:45 24 Q. It's Ronald. Okay.

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12:46 1 but that would be the only time that I would have  
 12:46 2 been his direct supervisor.  
 12:46 3 Q. What about Dr. Arturo Sevilla?  
 12:47 4 A. I know a Dr. Sevilla, but it was not  
 12:47 5 Arturo. It was -- it was a female. I don't  
 12:47 6 remember her first name though.  
 12:47 7 Q. And how do you know Dr. Sevilla?  
 12:47 8 A. She was a staff physician at -- at  
 12:47 9 Stateville Correctional Center but only for a brief  
 12:47 10 period of time.  
 12:47 11 Q. Does Dr. Sevilla still work at Wexford,  
 12:47 12 to your knowledge?  
 12:47 13 A. No, she does not.  
 12:47 14 Q. Do you know when Dr. Sevilla left?  
 12:47 15 A. I don't recall the dates, no.  
 12:47 16 Q. Are you aware of any corrective actions  
 12:47 17 issued to Dr. Sevilla?  
 12:48 18 A. No, I'm not aware of any.  
 12:48 19 Q. Do you know why she left?  
 12:48 20 A. No, I don't recall. It's not for  
 12:48 21 everybody. Corrections is a unique environment,  
 12:48 22 and some doctors just don't like it.  
 12:48 23 Q. Fair enough. Okay. We are about to  
 12:48 24 turn to the procedures or some procedures handbook.

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12:45 1 And you indirectly supervise  
 12:45 2 Dr. Shaefer?  
 12:45 3 A. Yes. Actually at one point directly.  
 12:45 4 He had different positions in the company.  
 12:45 5 Q. Okay. And do you recall any corrective  
 12:45 6 actions being issued to Dr. Shaefer?  
 12:45 7 A. Not that I recall, no.  
 12:45 8 Q. And the corrective actions, is that a  
 12:45 9 written notice?  
 12:46 10 A. It could be written or verbal.  
 12:46 11 Generally, it would be done in writing,  
 12:46 12 memorialized in writing.  
 12:46 13 Q. Okay. Are you familiar with a Dr. Magid  
 12:46 14 Fahim?  
 12:46 15 A. Yes.  
 12:46 16 Q. What is your familiarity with Dr. Fahim?  
 12:46 17 A. He was the medical director at Menard  
 12:46 18 for a period of time.  
 12:46 19 Q. Did you have any supervisory duties with  
 12:46 20 regards to Dr. Fahim?  
 12:46 21 A. No. The only exception, in that brief  
 12:46 22 period of time when I was solo in the state, that  
 12:46 23 if that happened to coincide -- and I don't  
 12:46 24 remember if he was medical director at that time,

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12:48 1 Let's see. I will mark the Wexford Health Provider  
 12:49 2 Handbook as Exhibit No. 2, and I will share my  
 12:49 3 screen.  
 12:50 4 Dr. Funk, can you see my screen now?  
 12:50 5 A. Yes, I can.  
 12:50 6 Q. And I will --  
 12:50 7 A. Better. Thank you.  
 12:50 8 Q. Okay. So we are looking at Exhibit  
 12:50 9 No. 2, which is the Wexford Health Provider  
 12:50 10 Handbook, so I'm just going to ask you some  
 12:50 11 background questions about this.  
 12:50 12 So, first of all, do you know who puts  
 12:50 13 together this provider handbook?  
 12:50 14 A. The person who signs it. There's a  
 12:50 15 signature on the second page. So it's put out by  
 12:51 16 the corporation, but the person who reviews it and  
 12:51 17 updates it -- it should have a signature on the  
 12:51 18 second page. It probably is the corporate medical  
 12:51 19 officer, chief medical officer.  
 12:51 20 Q. Okay. Let's see.  
 12:51 21 A. There it is.  
 12:51 22 Q. So Dr. Thomas Lehman, the corporate  
 12:51 23 medical director?  
 12:51 24 A. Lehman, yes.



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12:51 1 Q. Does anyone else review it besides  
 12:51 2 Dr. Lehman?  
 12:51 3 A. Whoever he chooses. He's the one who  
 12:51 4 does the final review and issues it. He may give  
 12:51 5 it to other individuals for their opinion.  
 12:51 6 Actually, I have been asked to give an opinion on  
 12:51 7 the -- and make changes to the physician handbook,  
 12:52 8 but it's at his discretion.  
 12:52 9 Q. Okay. And what is the purpose of this  
 12:52 10 handbook?  
 12:52 11 A. It's used in orientation of a new  
 12:52 12 provider to give them information about the company  
 12:52 13 and corrections and the specific population that we  
 12:52 14 provide services to.  
 12:52 15 Q. Can you give me more detail about how  
 12:52 16 it's used in training?  
 12:52 17 A. Yes. It's handed to the new applicant  
 12:52 18 as a prospective employee to review, and it is  
 12:52 19 reviewed -- I review it with the providers during  
 12:52 20 my orientation with them.  
 12:52 21 Q. Are you --  
 12:52 22 A. I'm sorry. And in that review, they  
 12:52 23 have the opportunity to ask questions about any of  
 12:53 24 the contents of the handbook.

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12:53 1 Q. Do you have this particular handbook? I  
 12:53 2 believe this is the one effective November 21,  
 12:53 3 2016, with you or near you?  
 12:53 4 A. No.  
 12:53 5 Q. Okay. We'll keep it up on the screen  
 12:53 6 then.  
 12:53 7 Now, you mentioned that you hand this  
 12:53 8 handbook to the people that you are training and go  
 12:53 9 through it with them. Are there particular  
 12:53 10 sections -- and I'll look at the table of  
 12:53 11 context -- that you go through with physicians?  
 12:53 12 A. No. I hand it to them in advance, ask  
 12:53 13 them to read it, and then I go over it with them  
 12:53 14 page by page or section by section and ask -- give  
 12:53 15 them the opportunity of asking any questions  
 12:53 16 relative to those areas.  
 12:53 17 Q. Okay. Just so I understand, you go over  
 12:54 18 the entire handbook with them?  
 12:54 19 A. Yes.  
 12:54 20 Q. Okay. To make things easier, when I  
 12:54 21 refer to it, I'll highlight it so you can see what  
 12:54 22 I'm talking about.  
 12:54 23 A. Okay. Could I ask for maybe one more  
 12:54 24 magnification? Okay. Great. Thanks.

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12:54 1 Q. So I highlighted a particular passage on  
 12:55 2 page 3 of Exhibit No. 2.  
 12:55 3 A. Yes.  
 12:55 4 Q. It says, All readers are encouraged to  
 12:55 5 consult their site specific operational policies  
 12:55 6 and procedures with regards to facility protocols.  
 12:55 7 Did I read that accurately?  
 12:55 8 A. Yes.  
 12:55 9 Q. When you train physicians, do you hand  
 12:55 10 them a copy of their site specific operational  
 12:55 11 policies and procedures?  
 12:55 12 A. Some of them. Yeah, some of them would  
 12:55 13 be at the facility, and they would evolve. They  
 12:55 14 would receive those during time, and some of them  
 12:55 15 they would receive in training from other  
 12:55 16 individuals. But some of them, yes.  
 12:55 17 Q. Going to page 5 now of this handbook.  
 12:56 18 If you look at letter E.  
 12:56 19 A. Yes.  
 12:56 20 Q. Is there a chronic clinic for rheumatoid  
 12:56 21 arthritis patients?  
 12:56 22 A. Not specifically for rheumatoid  
 12:56 23 arthritis patients. There's a general medical  
 12:56 24 clinic in which a rheumatoid arthritis patient can

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12:56 1 be added to, where they would be seen on a  
 12:56 2 scheduled basis, but there's not specifically a  
 12:56 3 rheumatoid arthritis clinic.  
 12:56 4 Q. How would an inmate get added to that  
 12:56 5 specific medical clinic, where they could be seen  
 12:56 6 on a regular basis for their rheumatoid arthritis?  
 12:56 7 A. At the discretion of the clinician, if  
 12:57 8 they chose to see him in a structured clinic, such  
 12:57 9 as the general medical clinic, they could do that  
 12:57 10 by assigning them to the clinic. That would be  
 12:57 11 something written that would indicate them to be  
 12:57 12 added to the general medical clinic.  
 12:57 13 Q. In your experience, if a patient was  
 12:57 14 experiencing active symptoms with regards to  
 12:57 15 rheumatoid arthritis, would you find it acceptable  
 12:57 16 for a physician to refer them to the general  
 12:57 17 medical clinic?  
 12:57 18 A. Yes.  
 12:57 19 Q. I just highlighted a particular passage  
 12:58 20 on page 5. Do you see this reads, Wexford Health  
 12:58 21 has an extensive manual on chronic care clinics to  
 12:58 22 help you with the management of these disease  
 12:58 23 states. Do you see that part?  
 12:58 24 A. Yes.



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12:58 1 Q. Is there a manual for the general  
12:58 2 medical clinic?  
12:58 3 A. No.  
12:58 4 Q. As you sit here today, do you know of a  
12:58 5 manual that specifically references how to care for  
12:58 6 patients with rheumatoid arthritis?  
12:58 7 A. No. Not a manual, no.  
12:58 8 Q. You are saying not a manual. Is there  
12:58 9 other documentation?  
12:58 10 A. It may be in the medical guidelines. It  
12:58 11 may be mentioned in the medical guidelines. I  
12:59 12 don't know that offhand. I did not have time to  
12:59 13 review that.  
12:59 14 Q. Is that something that you would  
12:59 15 typically review?  
12:59 16 A. Review in what sphere, in what setting?  
12:59 17 Q. In preparation for a deposition.  
12:59 18 A. I would review all information that was  
12:59 19 provided and relative to the deposition, so, yes, I  
12:59 20 would generally review that, if I had the time.  
12:59 21 Q. Now moving on to page 6 of Exhibit  
13:00 22 No. 2. I highlighted a particular paragraph.  
13:00 23 Sorry. My computer is being -- give me one second.  
13:01 24 A. Sure. It's way too small. You are

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13:01 1 going to have to blow it up, but I do see it, that  
13:01 2 it is there.  
13:01 3 Q. I need to blow it up, is what you said?  
13:01 4 A. Yes. Yes, please.  
13:01 5 Q. Okay.  
13:01 6 A. Now what is happening is, it's getting  
13:01 7 cut off, as it's getting larger.  
13:01 8 Q. Let me -- I know what I can do. Okay.  
13:02 9 Can you see it now?  
13:02 10 A. Yes.  
13:02 11 Q. Now, I highlighted a particular passage,  
13:02 12 and I'm going to start reading below that passage  
13:02 13 though and then come back to it.  
13:02 14 A. Okay.  
13:02 15 Q. Starting with what is marked as A, Many  
13:02 16 variables must be considered when deciding a course  
13:02 17 of treatment. These include but are not limited to  
13:02 18 the following. Did I read that accurately?  
13:02 19 A. Yes.  
13:02 20 Q. Now, I'm going to skip down to letter D.  
13:02 21 Letter D is, Whether the problem initiated in the  
13:03 22 Department of Corrections or prior to  
13:03 23 incarceration. So why is D relevant when  
13:03 24 considering -- when deciding a course of treatment?

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13:03 1 A. To define what the condition is and what  
13:03 2 the course of action should be. The time of when  
13:03 3 the illness developed would be relevant and it  
13:03 4 would -- the decision of treatment would be  
13:03 5 impacted by their current incarceration status.  
13:03 6 So some conditions that are longstanding  
13:03 7 would -- the impact of incarceration would impact  
13:03 8 on the decision of treatment or what type of  
13:03 9 treatment would be relevant.  
13:04 10 Q. So let's go to letter F. How long is  
13:04 11 the inmate's sentence? When will he or she be  
13:04 12 released? Why is that an important variable to  
13:04 13 consider when deciding a course of treatment?  
13:04 14 A. There's something in medicine called  
13:04 15 continuity of care. That is when a condition is  
13:04 16 treated, the effort should be made to complete the  
13:04 17 course of treatment, so that if a person has a  
13:04 18 complication, they are under the same care of the  
13:04 19 same provider. Incarceration for most instances is  
13:04 20 a temporary housing situation, where they are  
13:04 21 housed from a place where they don't reside. So  
13:04 22 should they have a complication from treatment or  
13:05 23 should their release not allow the treatment to be  
13:05 24 completed, that could negatively impact on their

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13:05 1 care.  
13:05 2 For example, this comes up for treatment  
13:05 3 for Hepatitis C, which is a very costly treatment,  
13:05 4 and it is generally not accessible in the community  
13:05 5 because of its cost. But because it's a viral  
13:05 6 illness, it has an adverse result to have that  
13:05 7 treatment interrupted, and knowing that a person is  
13:05 8 going to be released would be a reason not to  
13:05 9 implement treatment while they are incarcerated  
13:05 10 because it would actually worsen the illness when  
13:05 11 it was incompletely treated. It could cause a  
13:05 12 viral resistance to occur.  
13:05 13 Similarly, if a person is not there to  
13:06 14 have the treatment completed, it would be -- you  
13:06 15 know, for example, in surgery, the physician would  
13:06 16 need to know that the person was in the facility or  
13:06 17 in custody for a procedure to be done and  
13:06 18 scheduled. It often takes months before a  
13:06 19 procedure can be -- with all of the necessary  
13:06 20 preoperative things that need to be done and the  
13:06 21 scheduling, you would not want the person to be  
13:06 22 released shortly before surgery or not have the  
13:06 23 surgery -- be able to accomplish the surgery while  
13:06 24 the person was incarcerated. So the date -- the

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13:06 1 length of time that the person will be a patient of  
 13:06 2 the physician is relevant.  
 13:06 3 Q. Is that consideration relevant when it  
 13:06 4 comes to treatment for rheumatoid arthritis, in  
 13:07 5 particular prescribing methotrexate?  
 13:07 6 A. It may. If I had a patient who was soon  
 13:07 7 going to be released, I probably would not start  
 13:07 8 them on methotrexate because it's an  
 13:07 9 immunosuppressive drug that requires monitoring,  
 13:07 10 and it could potentially harm a patient where they  
 13:07 11 likely will not have access to a provider in the  
 13:07 12 community. But it would depend on the individual  
 13:07 13 circumstance. If the person said they did have a  
 13:07 14 physician -- which most of them don't, but if they  
 13:07 15 happened to say they would, then I would not have  
 13:07 16 that concern.  
 13:07 17 But there is concern, particular  
 13:07 18 concern, with that medication because of its  
 13:08 19 immunosuppressive -- it depresses the person's  
 13:08 20 resistance against fighting off infections. And,  
 13:08 21 again, it would depend on a number of other  
 13:08 22 factors. The general health of the patient, their  
 13:08 23 age. There's a number of factors that would be  
 13:08 24 considered and impact on my decision to treat

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13:08 1 somebody or not.  
 13:08 2 Q. Okay. And in a similar scenario where  
 13:08 3 someone is temporarily transferred to a facility  
 13:08 4 but that is not their home facility, would you  
 13:08 5 delay prescribing methotrexate until they got back  
 13:08 6 to their home facility?  
 13:08 7 A. Perhaps. It depended on where they were  
 13:08 8 transferred and how long before they were going to  
 13:08 9 be released. Whenever there's transition, it opens  
 13:08 10 up the door for something not going right. It just  
 13:08 11 increases the possibility of miscommunication of  
 13:08 12 that.  
 13:08 13 So there is a general principle that you  
 13:08 14 try to -- you take those factors into  
 13:09 15 consideration, and it's best to have the person at  
 13:09 16 one site for treatment with oversight of one  
 13:09 17 provider rather than adding other people, but it's  
 13:09 18 not a strict consideration. It's not something  
 13:09 19 that would always be done. Again, it would depend  
 13:09 20 on what the medication was, what the purpose of the  
 13:09 21 medication was, how much the person needed the  
 13:09 22 medication, you know, what the -- all of those  
 13:09 23 factors would make -- would be relevant.  
 13:09 24 Q. Do you know if methotrexate -- am I

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13:09 1 saying that right?  
 13:09 2 A. Yes. You got that one right. Very  
 13:09 3 good.  
 13:09 4 Q. Do you know if that is available in the  
 13:09 5 commissary at --  
 13:09 6 A. No.  
 13:09 7 Q. Sorry. Go ahead.  
 13:09 8 A. I cut you off, but you were saying is it  
 13:09 9 available at the commissary?  
 13:09 10 Q. Yeah. I asked, is it available at the  
 13:09 11 commissary?  
 13:09 12 A. No. No, it is a prescription drug. It  
 13:10 13 is not available in the commissary. It can only be  
 13:10 14 issued with a prescription by a physician or a  
 13:10 15 provider.  
 13:10 16 Q. And walk me through how the inmates, if  
 13:10 17 they are prescribed that medicine, how would they  
 13:10 18 receive it then?  
 13:10 19 A. They would receive it from a nurse that  
 13:10 20 would either provide it on a daily basis and most  
 13:10 21 likely would be provided that way. Or it can be  
 13:10 22 issued on what is called a blister pack, which is a  
 13:10 23 card that has little bays of the medication, where  
 13:10 24 the patient pushes through the plastic bay and it

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13:10 1 pops out the back through foil, and they would take  
 13:10 2 it themselves. It depends on how the physician  
 13:10 3 would order it. This medication generally is a  
 13:10 4 witness dose medication or a nurse administered  
 13:11 5 medication rather than a keep-on-person medication,  
 13:11 6 as the other example.  
 13:11 7 Q. For methotrexate, if it's issued on a  
 13:11 8 daily basis and you skip doses for various reasons,  
 13:11 9 in your experience, are there side effects?  
 13:11 10 A. There are not side effects. It's less  
 13:11 11 effective because the medication is not in the  
 13:11 12 system, but it would actually be the opposite.  
 13:11 13 There would be less side effects or potential for  
 13:11 14 side effects if it's not taken. The side effects  
 13:11 15 arise from taking the medication, and invariably it  
 13:11 16 depresses the immune system.  
 13:11 17 Q. Okay.  
 13:11 18 A. That is not a side effect. That is a  
 13:11 19 result of taking the medication and a concern,  
 13:11 20 therefore, of the medication or the use of the  
 13:11 21 medication.  
 13:11 22 Q. We are now moving on to page 7 of  
 13:12 23 Exhibit No. 2. I'm going to ask you a few  
 13:12 24 questions.

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13:12 1 Are you familiar with the National  
 13:12 2 Commission on Correctional Health Care standards?  
 13:12 3 A. Yes.  
 13:12 4 Q. And are the most recent standards  
 13:12 5 provided to the physicians that work at your sites?  
 13:12 6 A. They may have the standards at the  
 13:12 7 facility, but many of them have them -- have  
 13:12 8 obtained them on their own because they have the  
 13:12 9 certification, the CCHP certification, and the  
 13:13 10 standards are part of the certification. Review of  
 13:13 11 them is necessary for the certification. Most of  
 13:13 12 our providers are CCHP certified.  
 13:13 13 Q. Do you recall whether Dr. Obaisi was  
 13:13 14 CCHP certified?  
 13:13 15 A. No, I don't recall.  
 13:13 16 Q. What about the American Correctional  
 13:13 17 Association standards, are your physicians provided  
 13:13 18 with those standards?  
 13:13 19 A. They may be at the site, at the  
 13:13 20 facility. We do not provide them directly as a  
 13:13 21 company policy. We do not provide those standards.  
 13:13 22 The facility may have them at the site, but we  
 13:13 23 don't provide them.  
 13:13 24 Q. Okay. Now, there's something in

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13:14 1 Section IV referred to as the negotiated health  
 13:14 2 service contract. Do you see that?  
 13:14 3 A. Yes.  
 13:14 4 Q. Okay. What is that?  
 13:14 5 A. That is the contract that exists between  
 13:14 6 Wexford, the Illinois Department of Corrections,  
 13:14 7 and Health and Family Services.  
 13:14 8 Q. And are the physicians provided with a  
 13:14 9 copy of that contract?  
 13:14 10 A. It is at the facility. It is also  
 13:14 11 online, yes.  
 13:14 12 Q. You said it's also online?  
 13:14 13 A. Yes.  
 13:14 14 Q. Okay. Do you have separate employment  
 13:14 15 agreements with each of the physicians that are  
 13:14 16 employed at the site?  
 13:14 17 A. Yes.  
 13:14 18 Q. And do you have separate employment  
 13:14 19 agreements with each of the nurses that are  
 13:14 20 employed at the site?  
 13:14 21 A. Yes.  
 13:14 22 Q. I assume those are written agreements;  
 13:15 23 is that accurate?  
 13:15 24 A. Yes.

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13:15 1 Q. Now, on page 9 of Exhibit 2 -- and I'm  
 13:15 2 highlighting the passage for you. So this is  
 13:15 3 Section I on page 9 of Exhibit 2. And the passage  
 13:15 4 that I highlighted says, At your disposal are two  
 13:15 5 cardiologists, a Hepatitis C and infectious disease  
 13:15 6 specialist, a nephrologist, a rheumatologist, an  
 13:16 7 internist, a family practice physician, and a wound  
 13:16 8 care specialist. Did I read that accurately?  
 13:16 9 A. Yes.  
 13:16 10 Q. Who is the rheumatologist that you would  
 13:16 11 go to for your region?  
 13:16 12 A. I'm not sure I understand the question.  
 13:16 13 What do you mean in my region?  
 13:16 14 Q. I'm sorry. I missed the last part of  
 13:16 15 your response.  
 13:16 16 A. I'm not sure what you mean by "the  
 13:16 17 rheumatologist in my region."  
 13:16 18 Q. Okay. Let me ask a better question.  
 13:16 19 Who are these corporate medical  
 13:16 20 directors that are referred to on page 9?  
 13:16 21 A. There's a number of corporate medical  
 13:17 22 directors, so they would be situated in the  
 13:17 23 corporate office in Pittsburgh.  
 13:17 24 Q. And is one of them a rheumatologist?

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13:17 1 A. A rheumatologist was not a corporate  
 13:17 2 medical director. He was a physician, but he was  
 13:17 3 not a medical director.  
 13:17 4 Q. So who is that rheumatologist then?  
 13:17 5 A. His name escapes me right now. It might  
 13:17 6 actually be on the bottom of the document, if you  
 13:18 7 go all of the way to the end, if you want to do  
 13:18 8 that. I believe it's listed there.  
 13:18 9 Q. All of the way at the end of the  
 13:18 10 document; is that what you are saying?  
 13:18 11 A. Yes. I believe if you go all of the way  
 13:18 12 to the end, his name would be listed with the  
 13:18 13 extension or contact number.  
 13:18 14 Q. Okay. When we get to that part, I'll  
 13:18 15 show it to you and ask you --  
 13:18 16 A. Okay.  
 13:18 17 Q. -- if it jogs your memory.  
 13:18 18 So we are on page 12 of Exhibit No. 2,  
 13:18 19 and under Interview Techniques, No. 2 says, Have as  
 13:19 20 much knowledge as possible at hand when you start  
 13:19 21 the interview. Review the inmate chart (if one is  
 13:19 22 available). A few minutes of chart review will  
 13:19 23 save you considerable duplication of work and  
 13:19 24 evaluation. Did I read that accurately?

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13:19 1 A. Just a second, please. My computer is  
 13:19 2 telling me my battery is running low. I have to  
 13:19 3 make sure that I'm plugged in here.  
 13:20 4 Okay. I think I'm plugged in now. I'm  
 13:20 5 sorry. Could you please repeat the last question?  
 13:20 6 Q. Yes, I can. So I was reading under  
 13:20 7 Section B, Interview Techniques, No. 2 says, have  
 13:19 8 as much knowledge as possible at hand when you  
 13:19 9 start the interview. Review the inmate chart (if  
 13:19 10 one is available). A few minutes of chart review  
 13:19 11 will save you considerable duplication of work and  
 13:19 12 evaluation. Did I read that accurately?  
 13:20 13 A. Yes.  
 13:20 14 Q. During your time as the regional medical  
 13:20 15 director, have the inmate charts been in paper  
 13:20 16 format?  
 13:20 17 A. Yes. The majority of them have been,  
 13:20 18 except for the female system, which is on a  
 13:20 19 computerized system.  
 13:20 20 Q. Can you say that last part one more  
 13:20 21 time?  
 13:20 22 A. The female sites are computerized, but  
 13:21 23 the male sites, which are the majority, are paper.  
 13:21 24 Q. I want to scroll up. So one of the

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13:21 1 things that I have seen in this handbook a couple  
 13:21 2 of times is references to inmates and manipulation.  
 13:21 3 Why is it important when you are training  
 13:21 4 physicians to discuss this?  
 13:21 5 A. Because it's a consideration in  
 13:21 6 treatment of a patient, that some can be  
 13:21 7 manipulative, and that is a factor that is  
 13:21 8 considered in treating patients.  
 13:22 9 Q. And how is that factor considered in  
 13:22 10 treating them?  
 13:22 11 A. It's a factor that is considered in  
 13:22 12 determining what treatment should be appropriate  
 13:22 13 for a specific patient, so it is something that is  
 13:22 14 relevant in interactions with a patient, that one  
 13:22 15 would consider that they may be manipulative.  
 13:22 16 Q. Okay. Let's move on to the next page.  
 13:22 17 So I'm looking at No. 8, and I'm going to highlight  
 13:22 18 some text from that. So No. 8 says -- the first  
 13:22 19 three words are in all caps -- DO NOT EVER explain  
 13:23 20 symptoms you would expect to see to confirm a  
 13:23 21 diagnosis to an inmate. If you should, those  
 13:23 22 symptoms will likely be present with the next  
 13:23 23 visit. Did I read that accurately?  
 13:23 24 A. Yes.

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13:23 1 Q. Okay. And what is the purpose behind  
 13:23 2 this recommendation in particular, those two  
 13:23 3 sentences that I read?  
 13:23 4 A. So some patients can be suggested to  
 13:23 5 have an illness from symptoms that are explained by  
 13:23 6 a clinician. About a third of our population have  
 13:23 7 mental illness, and that population or patients who  
 13:23 8 have mental illness can -- are suggestible to be --  
 13:23 9 to sometimes believe they have symptoms that are  
 13:23 10 suggested from an interview. So in our -- for that  
 13:23 11 reason, that is why this statement is written.  
 13:24 12 It's advised not to suggest symptoms, but rather to  
 13:24 13 ask open-ended questions of what a person has. Not  
 13:24 14 suggest, for example, do you have this? Because a  
 13:24 15 tendency in some patients is to answer yes to any  
 13:24 16 question.  
 13:24 17 Q. Okay. And so in that situation, in your  
 13:24 18 experience, are there times where an inmate may  
 13:24 19 have symptoms that could help your diagnosis but  
 13:24 20 just doesn't know to verbalize those particular  
 13:24 21 symptoms?  
 13:24 22 A. No. I would say they may not be able to  
 13:25 23 explain it in the way that is -- another person  
 13:25 24 might be able to, but they are able to communicate

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13:25 1 what their symptom is, just using different words  
 13:25 2 that you might see from another person.  
 13:25 3 So, no, I don't think that there's any  
 13:25 4 restriction or limitation on a person being able to  
 13:25 5 express those symptoms, and if the physician  
 13:25 6 thought that, they could ask the question or  
 13:25 7 suggest something. These are -- this is a general  
 13:25 8 guideline. It does not apply, as the preface  
 13:25 9 states, to every specific patient.  
 13:25 10 Q. So in your experience physicians might  
 13:25 11 ask questions about particular symptoms if they  
 13:25 12 thought it was appropriate?  
 13:25 13 A. Yes. Yes, absolutely.  
 13:25 14 Q. Moving on to page 15 of Exhibit No. 2,  
 13:26 15 and at the top, Section I is Intake Reception and  
 13:26 16 Classification?  
 13:26 17 A. Yes.  
 13:26 18 Q. I'm going to highlight the first  
 13:26 19 sentence of the second paragraph, which reads,  
 13:26 20 Within 14 days following the intake screening, a  
 13:26 21 complete history and physical examination should be  
 13:26 22 completed, including whatever routine and other  
 13:26 23 indicated laboratory and biometric testing is  
 13:26 24 indicated to establish claimed problems. Did I

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13:26 1 read that accurately?

13:26 2 A. Yes.

13:26 3 Q. Is it fair to say that you would expect

13:27 4 each inmate to have a full complete history and

13:27 5 examination in their file from their intake?

13:27 6 A. Yes, except if they refused it.

13:27 7 Q. How often do inmates refuse it, in your

13:27 8 experience?

13:27 9 A. The intake physical, not that commonly,

13:27 10 or they may refuse a part of it. There's an

13:27 11 unpleasant exam that used to be part of the exam,

13:27 12 called a rectal exam. That is commonly refused,

13:27 13 but the entire exam, just a few percent will refuse

13:27 14 the exam completely.

13:27 15 Q. Okay. Going to page 17 of Exhibit

13:28 16 No. 2. I'm highlighting the last sentence of the

13:28 17 first paragraph on that page that reads, If you, as

13:28 18 responsible physician, believe specialty services

13:28 19 are indicated and identify a medical need, the case

13:28 20 must be discussed in collegial review. Please

13:28 21 review the utilization management policies and

13:28 22 procedures for all off-site care. Did I read that

13:28 23 accurately?

13:28 24 A. Yes.

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13:28 1 Q. Now, as we discussed earlier, the

13:28 2 collegial review process is no longer in place as

13:28 3 of today; is that correct?

13:28 4 A. Correct.

13:28 5 Q. But for the entire time that you have

13:28 6 been medical director, so since 2005, up until

13:28 7 about six months ago, the collegial review process

13:28 8 was in place; is that correct?

13:28 9 A. Nine months ago, yes.

13:28 10 Q. Nine months ago. Okay.

13:29 11 When a collegial review happens, is

13:29 12 there any documentation that is made concerning the

13:29 13 collegial review?

13:29 14 A. Yes, there is.

13:29 15 Q. And what is the documentation?

13:29 16 A. From the physician's end, it would be in

13:29 17 the progress notes, and from the corporate end, it

13:29 18 would be in their records, their computer system.

13:29 19 Q. And when you reviewed the records for

13:29 20 the plaintiff's case, did you see documentation of

13:29 21 a collegial review?

13:29 22 A. Yes.

13:29 23 Q. And what documentation did you see?

13:29 24 A. That it took place, and that there was

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13:29 1 an approval for a rheumatology visit, for one, and

13:29 2 then there were some others. It must have been

13:29 3 because he had some specialized testing, MRIs.

13:30 4 There must have been. I just don't recall them,

13:30 5 but they must be in there.

13:30 6 Q. And did you see both the corporate

13:30 7 documentation and the progress notes with regards

13:30 8 to the collegial review?

13:30 9 A. Yes.

13:30 10 Q. Okay. We are now on the last page, and

13:31 11 I just wanted to come to this page of Exhibit No. 2

13:31 12 to see if one of these names rung a bell for the

13:31 13 rheumatologist?

13:31 14 A. Yeah. Is there another part to it?

13:31 15 These are the other people that would have been

13:31 16 referenced in that paragraph, but the

13:31 17 rheumatologist -- I think his name was Breen,

13:31 18 B-r-e-e-n, if I recall correctly. Does it continue

13:31 19 onto the next page or no?

13:31 20 Q. This is all I have.

13:31 21 A. It's not there.

13:31 22 Q. So it possibly does.

13:31 23 A. He's not added, but they don't list it

13:31 24 here.

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13:31 1 Q. Okay. Well, I will stop sharing my

13:31 2 screen.

13:31 3 MR. LOMBARDO: Would this be a good time for

13:31 4 maybe just a five-minute bathroom break?

13:32 5 MS. REED: Yes, that is fine.

13:32 6 MR. LOMBARDO: Thank you very much.

13:32 7 MS. REED: Let's go off the record.

13:32 8 (WHEREUPON, a recess was had.)

13:32 9 BY MS. REED:

13:45 10 Q. Dr. Funk, do you understand that you are

13:45 11 still under oath?

13:45 12 A. I do.

13:45 13 Q. Okay. Let's continue. Are inmates

13:45 14 allowed to request treatment from an outside

13:45 15 physician?

13:45 16 A. They can request it, yes.

13:45 17 Q. Then what happens after they request it?

13:45 18 A. The physician evaluates them, if that

13:45 19 request is appropriate or not, and then makes a

13:45 20 decision accordingly.

13:45 21 Q. And if the physician agrees with that

13:45 22 request, then does it go up to the collegial

13:45 23 review?

13:45 24 A. Yes.

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13:45 1 Q. Is there any way to bypass the collegial  
 13:46 2 review?  
 13:46 3 A. Yes. There would be a way around that.  
 13:46 4 Q. How is that?  
 13:46 5 A. Well, there's a few ways. So if it was  
 13:46 6 an emergency, there's no collegial review for that,  
 13:46 7 or an urgent thing/matter. The physician would  
 13:46 8 have the latitude to do that.  
 13:46 9 The agency medical director could  
 13:46 10 authorize treatment or a procedure bypassing the  
 13:46 11 collegial review, so those would be the common  
 13:46 12 ways.  
 13:46 13 Q. Okay. And once a collegial review --  
 13:46 14 when it results in a yes for the physician and the  
 13:46 15 physician can refer out, how do you choose who the  
 13:46 16 case or the patient is referred to outside of  
 13:46 17 Wexford?  
 13:46 18 A. The physician would determine which  
 13:46 19 provider would be utilized, so there is a list of  
 13:46 20 providers that are a specialist that see our  
 13:47 21 patients, and the provider would choose which  
 13:47 22 doctor should see the patient.  
 13:47 23 Q. Okay. Are there any restrictions on the  
 13:47 24 physician's choice of which provider should see the

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13:48 1 describe what that is?  
 13:48 2 A. It's called a formulary. There are  
 13:48 3 medications in specific groups that are preferred  
 13:48 4 for use by the company, so it's a company  
 13:48 5 formulary.  
 13:48 6 Q. And how does the company determine which  
 13:48 7 medications are preferred for use?  
 13:48 8 A. By a vote from the physicians that  
 13:48 9 worked for Wexford. They determine which  
 13:48 10 medications should be added or removed from the  
 13:49 11 formulary. There's a meeting that takes place, and  
 13:49 12 physicians and other clinicians will vote on what  
 13:49 13 medications should be added or removed.  
 13:49 14 Q. So is it all the physicians that work  
 13:49 15 for the company, or I guess how do you select which  
 13:49 16 physicians vote?  
 13:49 17 A. It would be at the direction of the  
 13:49 18 corporate medical officer, and it's a select group  
 13:49 19 of physicians and providers that would meet  
 13:49 20 specifically for that purpose.  
 13:49 21 Q. Okay. How does Wexford and you, in  
 13:49 22 particular, as a regional medical director, ensure  
 13:49 23 that your physicians are adhering to the standard  
 13:49 24 of care with regards to particular diseases and

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13:47 1 patient?  
 13:47 2 A. No.  
 13:47 3 Q. So it's completely up to the physician's  
 13:47 4 discretion?  
 13:47 5 A. It's up to the physician, if he has a  
 13:47 6 choice. He may not have a preference. In some  
 13:47 7 cases there may not be a preference for that, and  
 13:47 8 he'll just say whoever is available, but he may  
 13:47 9 express a specific -- or request a specific  
 13:47 10 physician to see the patient.  
 13:47 11 Q. Okay. If the inmate has a specific  
 13:47 12 physician in mind, someone they saw before or  
 13:47 13 someone a family recommended, would the physician  
 13:47 14 consider that as well?  
 13:47 15 A. They would consider it. Generally, if a  
 13:47 16 person had been seen, an effort would be made for  
 13:47 17 the physician -- for the patient to return to that  
 13:48 18 provider. But they can make a request, but it  
 13:48 19 would not be a determination. They could not make  
 13:48 20 that determination to see a specific person.  
 13:48 21 Q. Okay. Are you familiar with the  
 13:48 22 approved medication list?  
 13:48 23 A. Yes.  
 13:48 24 Q. Okay. And just for the record, can you

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13:49 1 diagnoses?  
 13:50 2 A. From reviewing and evaluating the  
 13:50 3 decisions that they make on an ongoing basis.  
 13:50 4 Q. Are your medical files and medical  
 13:50 5 decisions ever reviewed by outside physicians to  
 13:50 6 determine if your physicians are keeping to the  
 13:50 7 standard of care?  
 13:50 8 A. By outside physicians, you mean those  
 13:50 9 that are not working for Wexford? Is that what you  
 13:50 10 are saying?  
 13:50 11 Q. Correct. Yes.  
 13:50 12 A. And are you asking me if we engage  
 13:50 13 physicians working to do those reviews or they are  
 13:50 14 done by other parties?  
 13:50 15 Q. If Wexford engages physicians to review  
 13:50 16 their employed physicians.  
 13:50 17 A. No. All of the physicians that would  
 13:50 18 review others would be employed or engaged by  
 13:50 19 Wexford.  
 13:50 20 Q. Okay. Are you familiar with what is  
 13:51 21 referred to as a sick call?  
 13:51 22 A. Yes.  
 13:51 23 Q. And what is your understanding of what a  
 13:51 24 sick call is?



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13:51 1 A. Sick call is the term for a clinic  
 13:51 2 visit, so it would be what an office visit  
 13:51 3 equivalent would be in the community.  
 13:51 4 Q. In your experience, how are inmates able  
 13:51 5 to request a sick call?  
 13:51 6 A. The facility will define its procedure  
 13:51 7 through something called an inmate or offender  
 13:51 8 handbook, which will explain to them the procedure  
 13:51 9 for them to access sick call. Generally, for  
 13:52 10 nonemergent matters, it entails a sick call request  
 13:52 11 slip, so the offender or the inmate will fill out  
 13:52 12 the information, reason for his visit, and then  
 13:52 13 that is submitted to the health care unit and then  
 13:52 14 processed.  
 13:52 15 Q. And how does the health care unit  
 13:52 16 process that request?  
 13:52 17 A. A nurse reviews the request and then  
 13:52 18 refers it to the right source, or they may conduct  
 13:52 19 what is called nurse sick call, where they may  
 13:52 20 address common complaints by use of nursing  
 13:52 21 treatment protocols.  
 13:52 22 Q. To your knowledge, are there site  
 13:52 23 specific policies and procedures with regards to  
 13:52 24 processing sick calls?

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13:52 1 A. Yes. Each site has its own process,  
 13:53 2 depending on the facility makeup, its needs, so  
 13:53 3 each site has its own specific policies.  
 13:53 4 Q. And in your experience, are those  
 13:53 5 policies written policies?  
 13:53 6 A. They would be written, yes, and they  
 13:53 7 could also be verbally communicated to the  
 13:53 8 offenders, to the inmates. Generally, that is done  
 13:53 9 at orientation when they arrive at the facility.  
 13:53 10 Q. If you wanted to access a written policy  
 13:53 11 with regards to sick calls, is there an online  
 13:53 12 database that you can go to to access it, if you  
 13:53 13 need to?  
 13:53 14 A. No.  
 13:53 15 Q. How would you get ahold of that written  
 13:53 16 policy?  
 13:53 17 A. By requesting it from the facility, from  
 13:53 18 the health care unit administrator at the facility.  
 13:54 19 Q. Who is the health care unit  
 13:54 20 administrator at Stateville?  
 13:54 21 A. Her name is Galindo. I think  
 13:54 22 Lucecita -- Lucy Galindo, I believe is her first  
 13:54 23 name. Last name is Galindo, G-a-l-i-n-d-o.  
 13:54 24 Q. Okay. I'm going to essentially show you

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13:54 1 a string of documents and ask you questions about  
 13:54 2 them, but that is -- I'm nearing the end. Once we  
 13:54 3 get through these documents, we'll be close.  
 13:55 4 MS. REED: Counsel, do you want me to continue  
 13:55 5 sending the exhibits in the chat?  
 13:55 6 MR. LOMBARDO: As long as you are screen  
 13:55 7 sharing them, that is fine with me. I'm not using  
 13:55 8 the ones in the chat, but thanks for asking.  
 13:55 9 BY MS. REED:  
 13:55 10 Q. So I'll show you what will be marked as  
 13:55 11 Exhibit No. 3. Can you see Exhibit No. 3?  
 13:56 12 A. Yes.  
 13:56 13 Q. Okay. Exhibit No. 3 is an excerpt from  
 13:56 14 the Wexford guidelines, and it refers to urgent  
 13:56 15 requests. Do you see that?  
 13:56 16 A. Yes.  
 13:56 17 Q. Okay. In particular, looking at the  
 13:57 18 procedure, starting with A, If the site medical  
 13:57 19 director or designee determines a need for urgent  
 13:57 20 medical services, the site personnel submits the  
 13:57 21 request outlining need for urgent request to the UM  
 13:57 22 department via e-mail. The e-mail must include the  
 13:57 23 word "urgent" in the subject heading to assist in  
 13:57 24 facilitating a timely response to the request.

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13:57 1 And I stopped before I read the last  
 13:57 2 sentence, and I omitted a part in brackets. Other  
 13:57 3 than that, did I read that accurately?  
 13:57 4 A. Yes.  
 13:57 5 Q. What is the UM department? Is that the  
 13:57 6 utilization management department?  
 13:57 7 A. Correct.  
 13:57 8 Q. So when you were reviewing the file for  
 13:57 9 this case, did you see e-mails marked "urgent" with  
 13:58 10 regards to the plaintiff?  
 13:58 11 A. No.  
 13:58 12 Q. Did you have access to the UM department  
 13:58 13 e-mails when you were preparing for this deposition  
 13:58 14 today?  
 13:58 15 A. There are notes that I have, yes.  
 13:58 16 Q. What I asked is, did you have access to  
 13:58 17 their e-mails with regard to the plaintiff?  
 13:58 18 A. Well, they didn't -- they are not  
 13:58 19 e-mails, but they are screen shots. So their  
 13:58 20 communication is written in their software, and  
 13:58 21 somehow they print out their documentation. So  
 13:58 22 it's not an e-mail communication. It's written in  
 13:58 23 the -- their software and then they print it out,  
 13:58 24 and it looks like a screen shot.

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13:58 1 Q. So what you have -- go ahead.  
 13:58 2 A. It does not look like an e-mail, but  
 13:58 3 it's their communication.  
 13:58 4 Q. When you say "their communication," do  
 13:59 5 you mean the UM department's communication?  
 13:59 6 A. Correct, yes.  
 13:59 7 Q. Okay. And when you were looking at the  
 13:59 8 UM department communications, did you also see  
 13:59 9 communications from the site director, site medical  
 13:59 10 director in that?  
 13:59 11 A. I'm sorry. Go ahead.  
 13:59 12 Q. I guess what I want to understand is,  
 13:59 13 when you refer to the screen shots from the UM  
 13:59 14 department, do those screen shots include both  
 13:59 15 sides of the communication or just the UM's  
 13:59 16 response to something?  
 13:59 17 A. It's the UM's summary of the  
 13:59 18 conversation, which includes the communication from  
 13:59 19 the medical director.  
 13:59 20 Q. Does it include a summary of that  
 13:59 21 communication, or is the verbatim communication  
 13:59 22 attached to that?  
 13:59 23 A. No, it's a summary. It is not verbatim,  
 13:59 24 and there's nothing attached to it.

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13:59 1 Q. Okay. Now I'm going to mark Exhibit  
 14:00 2 No. 4. Dr. Funk, I'm going to blow this up a  
 14:00 3 little bit. Can you see what I'm displaying as  
 14:00 4 Exhibit No. 4?  
 14:00 5 A. Yes.  
 14:00 6 Q. Okay. Exhibit No. 4 is a grievance form  
 14:01 7 from plaintiff. It's dated December 11, 2014.  
 14:01 8 Does that appear accurate from your standpoint?  
 14:01 9 A. Yes, it does, but -- yeah, I remember  
 14:01 10 reviewing this. And I would be surprised if I was  
 14:01 11 incorrect, but I don't believe the words urgent  
 14:01 12 were on the top of it, at least the one that I  
 14:01 13 reviewed. I actually have that here. I can look  
 14:01 14 at that and verify it, to see if I'm right or not.  
 14:01 15 Can I do that?  
 14:01 16 Q. Yes. That is fine.  
 14:02 17 A. Okay. I'm wrong. First time it  
 14:02 18 happened. No, actually, that is correct. It did  
 14:02 19 say "urgent" on top. The other ones did not have  
 14:02 20 that written, but this is an accurate copy.  
 14:02 21 Q. Okay.  
 14:02 22 A. Thanks for letting me prove myself  
 14:02 23 wrong.  
 14:02 24 Q. Of course. And so I guess, based on

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14:03 1 what you just said, you have had a chance to review  
 14:03 2 this particular grievance; is that correct?  
 14:03 3 A. Yes, yes.  
 14:03 4 Q. Do you see at the bottom of this, there  
 14:03 5 is a box that is marked Emergency Review?  
 14:03 6 A. Yes.  
 14:03 7 Q. And can you tell who that signature is  
 14:03 8 for that?  
 14:03 9 A. It appears to be Mr. Daniels' signature.  
 14:03 10 Q. For the emergency review.  
 14:03 11 A. Yes. Where it says, Check only if an  
 14:03 12 emergency grievance.  
 14:03 13 Q. Sorry. We are on different sections.  
 14:03 14 That is my fault. I am looking at the very bottom  
 14:03 15 of page 1 of Exhibit 4.  
 14:03 16 A. Okay.  
 14:04 17 Q. Go ahead.  
 14:04 18 A. Could you please go up a little bit  
 14:04 19 higher? There's a black box. Stop there. Yeah,  
 14:04 20 actually a little bit higher. I have a black box  
 14:04 21 here that says, Introducing Zoom app. Can you go  
 14:04 22 up a little bit?  
 14:04 23 Q. Yes. I think the problem is when I go  
 14:04 24 up a little bit, it just goes to the next page.

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14:04 1 A. Okay. So --  
 14:04 2 Q. Let me see if I can figure that out.  
 14:04 3 A. Let me see if I can X that box out. I  
 14:04 4 got it. It's gone.  
 14:04 5 Q. Okay.  
 14:04 6 A. Yeah. So the name Tarry Williams  
 14:04 7 appears, and then something after that. I'm not  
 14:04 8 sure what that is, initials.  
 14:04 9 Q. Do you know a Tarry Williams?  
 14:04 10 A. It's the name of a warden. It probably  
 14:05 11 is him.  
 14:05 12 Q. Okay. I can go on to the next one. I'm  
 14:05 13 sorry. We are going to go back to that one really  
 14:05 14 quick.  
 14:06 15 We are on page 2 of Exhibit 4, and  
 14:06 16 towards the bottom of this page, there's a relief  
 14:06 17 requested. Do you see that?  
 14:06 18 A. Yes.  
 14:06 19 Q. Okay. And towards the end, it  
 14:06 20 references his joint pains. Do you see that?  
 14:06 21 A. Yes.  
 14:06 22 Q. It also references his out of range  
 14:06 23 rheumatoid factor?  
 14:06 24 A. Yes.

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14:06 1 Q. Are those the types of complaints that  
 14:06 2 you would expect to hear from somebody with  
 14:06 3 rheumatoid arthritis?  
 14:06 4 A. No.  
 14:06 5 Q. Why not?  
 14:06 6 A. Because patients generally don't report  
 14:07 7 their lab findings. It would be uncommon for a  
 14:07 8 patient to present this way. He is interpreting  
 14:07 9 his own laboratory results, and thereby may be  
 14:07 10 fluid by those results, which I believe he is, has  
 14:07 11 been.  
 14:07 12 Q. Now, what about the reference to the  
 14:07 13 joint pain? Is that a typical complaint for  
 14:07 14 someone with rheumatoid arthritis?  
 14:07 15 A. It's a part of the complaint that a  
 14:07 16 patient with rheumatoid arthritis will have, but it  
 14:07 17 will be characteristic -- a joint complaint is  
 14:07 18 nonspecific and is usually due to things other  
 14:07 19 than -- or, actually, it's rarely due to rheumatoid  
 14:07 20 arthritis. It's generally due to osteoarthritis,  
 14:08 21 which he has as well.  
 14:08 22 So this is not a -- to answer your  
 14:08 23 question. This is not the way that a patient would  
 14:08 24 present with -- he is distressed by his laboratory

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14:08 1 finding, which is clear, but a patient who has  
 14:08 2 symptoms of rheumatoid arthritis will be  
 14:08 3 distressed -- will present with the symptoms of  
 14:08 4 that and not like this at all.  
 14:08 5 Q. In your experience, do inmates have  
 14:08 6 access to their lab test results?  
 14:08 7 A. Yes, they do. That is how he obtained  
 14:08 8 it.  
 14:09 9 Q. You said, that is how he obtained them?  
 14:09 10 A. Yes, obviously he did. So they do have  
 14:09 11 access, and he obtained it.  
 14:09 12 Q. Okay. I'm going to go to the next one.  
 14:10 13 So I'm sharing with you Exhibit No. 5. Exhibit  
 14:10 14 No. 5 is labelled, Medical Policies and Procedures,  
 14:10 15 Region: Illinois. Do you see that?  
 14:10 16 A. Yes.  
 14:10 17 Q. And I believe that we received this from  
 14:10 18 your counsel yesterday?  
 14:10 19 A. Yes.  
 14:10 20 Q. And I think the note with it is that you  
 14:10 21 thought that it would helpful for this case; is  
 14:10 22 that accurate?  
 14:10 23 A. No. It would be helpful to review it,  
 14:10 24 that is what I said.

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14:10 1 Q. Okay. Could you explain why, in your  
 14:11 2 opinion, it would be helpful to review it?  
 14:11 3 A. Because you are likely to ask questions  
 14:11 4 on it, so that I can respond to those.  
 14:11 5 Q. Let me ask a better question. Is there  
 14:11 6 any particular section of this document that you  
 14:11 7 found relevant to the plaintiff's case?  
 14:11 8 A. No. I did not produce this or request  
 14:11 9 that this would be produced. It was done by  
 14:11 10 counsel.  
 14:11 11 Q. Okay. And did you review these medical  
 14:11 12 policies and procedures prior to this deposition  
 14:11 13 today?  
 14:11 14 A. Not for this deposition. I have  
 14:11 15 reviewed them in the past, but I did not have time  
 14:11 16 to review these, as I just received them yesterday.  
 14:11 17 Q. Okay. And in your past review or based  
 14:11 18 on your past review, is there any sections of this  
 14:11 19 document that are relevant to the diagnosis of  
 14:12 20 rheumatoid arthritis?  
 14:12 21 A. It may be. I have not committed it to  
 14:12 22 memory and there may be, but I don't know without  
 14:12 23 looking at it.  
 14:12 24 Q. Okay. I did not see any. I just wanted

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14:12 1 to make sure I was not missing any.  
 14:12 2 A. Okay.  
 14:12 3 Q. If there's a particular one that you  
 14:12 4 recall, then I just wanted to make sure that I knew  
 14:12 5 about it.  
 14:12 6 A. No, I don't recall, and there may not  
 14:12 7 be -- there may not be specifically for rheumatoid  
 14:12 8 arthritis.  
 14:12 9 Q. Okay.  
 14:12 10 MR. LOMBARDO: I know I'm not the deponent  
 14:12 11 here, but I did go through the policies and there  
 14:12 12 were none about rheumatoid arthritis.  
 14:13 13 MS. REED: Okay. Thank you.  
 14:13 14 MR. LOMBARDO: We produced the orthopedic  
 14:13 15 guidelines because there is mention of  
 14:13 16 osteoarthritis and the treatment for that. Okay?  
 14:13 17 MS. REED: Okay. And I noticed, upon  
 14:13 18 reviewing this, that the chronic pain management  
 14:13 19 section was missing.  
 14:13 20 MR. LOMBARDO: We can produce that.  
 14:13 21 MS. REED: Awesome. Thank you.  
 14:13 22 BY MS. REED:  
 14:13 23 Q. Okay. Moving on. Quick question,  
 14:14 24 Dr. Funk. When a grievance is filed by an inmate

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14:14 1 related to a medical issue, is that escalated to  
 14:14 2 you at any point?  
 14:14 3 A. Generally, no.  
 14:14 4 Q. Okay. You said, Generally, no. Have  
 14:14 5 there been times when it was escalated to you?  
 14:14 6 A. In isolated instances, if it involved a  
 14:14 7 matter that was found to be of substance, I may  
 14:14 8 be -- the incident may be referred to me, but not  
 14:14 9 for most grievances. It would be rare that that  
 14:14 10 would occur.  
 14:14 11 Q. So, to your knowledge, are those  
 14:14 12 grievances handled by the prison facility?  
 14:15 13 A. Yes. By the staff at the facility, yes.  
 14:15 14 Q. And is someone other than you from  
 14:15 15 Wexford typically involved in the grievance  
 14:15 16 process, if it's medically related?  
 14:15 17 A. Yes.  
 14:15 18 Q. And who would that be?  
 14:15 19 A. The person that was involved in the  
 14:15 20 matter would be interviewed. They would be -- they  
 14:15 21 would participate in it, and from that -- from the  
 14:15 22 investigation. The grievances that are found to  
 14:15 23 have merit are discussed -- at least those are  
 14:15 24 discussed at the monthly CQI meeting that occurs at

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14:15 1 the facility, and the regional manager and medical  
 14:15 2 director at least participate in those meetings.  
 14:15 3 But if there was something that was  
 14:15 4 found, for example, if it was something relating to  
 14:16 5 employee conduct or something like that, it could  
 14:16 6 be referred to me from the matter of grievance.  
 14:16 7 Q. You mentioned a monthly, what you called  
 14:16 8 a CQI meeting?  
 14:16 9 A. Yes.  
 14:16 10 Q. And what is that?  
 14:16 11 A. Continuous quality improvement, a  
 14:16 12 meeting that takes place on a monthly basis at the  
 14:16 13 facility.  
 14:16 14 Q. And does someone keep the meeting  
 14:16 15 minutes for those?  
 14:16 16 A. Yes.  
 14:16 17 Q. And that is a written document?  
 14:16 18 A. Yes.  
 14:16 19 Q. If you wanted to look back at prior  
 14:16 20 CQI meetings for Stateville, would you have access  
 14:16 21 to those meeting minutes?  
 14:16 22 A. They would be at the facility. I would  
 14:16 23 have to go to the facility, but they are kept there  
 14:17 24 and stored for a period of time.

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14:17 1 Q. Do you know how long?  
 14:17 2 A. No. They belong to the Department of  
 14:17 3 Corrections, so it would be according to their  
 14:17 4 policy.  
 14:17 5 Q. Now, with regards to corrective actions  
 14:17 6 for physicians, is there a database where those  
 14:17 7 corrective actions are stored that you know of?  
 14:17 8 A. Not a database. It would be in their  
 14:17 9 employee file, if it was a written discipline or a  
 14:17 10 written corrective action rather.  
 14:17 11 Q. Are the employee files digitized?  
 14:17 12 A. No. Well, whenever I see them, they are  
 14:17 13 in paper format, so I don't know what the corporate  
 14:17 14 office does, if they digitize them and then  
 14:17 15 undigitize them, but I get paper copy or paper  
 14:17 16 versions.  
 14:17 17 Q. Do you know where those paper versions  
 14:17 18 are held?  
 14:18 19 A. They are somewhere in the corporate  
 14:18 20 office. Maybe in the cloud, but it's not -- the  
 14:18 21 human resources department is in Pittsburgh.  
 14:18 22 Q. Do you know how long those corrective  
 14:18 23 actions remain in an employee's file?  
 14:18 24 A. Well, they remain permanently as long as

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14:18 1 the person is employed, and then for at least seven  
 14:18 2 years after they leave employment, their employee  
 14:18 3 file exists or is stored.  
 14:18 4 Q. Does Wexford scan copies of the patient  
 14:18 5 records or progress notes?  
 14:18 6 A. On isolated and specific instances, yes,  
 14:19 7 but not in general, no.  
 14:19 8 Q. We are going to look at a few progress  
 14:19 9 notes and then I promise we are almost done.  
 14:19 10 A. Okay.  
 14:19 11 Q. So I'm showing you what is marked as  
 14:20 12 Exhibit No. 6. Can you see Exhibit No. 6?  
 14:20 13 A. Yes.  
 14:20 14 Q. So Exhibit No. 6 is a form that is  
 14:20 15 labelled Illinois Department of Corrections,  
 14:20 16 Offender Outpatient Progress Notes, Stateville  
 14:20 17 Correctional Center?  
 14:20 18 A. Yes.  
 14:20 19 Q. And this first page of Exhibit No. 6  
 14:20 20 does not have any information, it just has an X on  
 14:20 21 it; is that right?  
 14:20 22 A. Yes.  
 14:20 23 Q. But is this the form that has been used  
 14:20 24 throughout your tenure as a regional medical

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14:20 1 director?

14:20 2 A. Yes.

14:20 3 Q. At any point during your tenure, did

14:20 4 this form change?

14:20 5 A. No.

14:20 6 Q. Okay. And these forms are stored at the

14:20 7 facilities after they are filled out?

14:20 8 A. Yes.

14:20 9 Q. Now I'm looking at page 2, and I just

14:21 10 want to go over how these forms are set up. So in

14:21 11 the left-hand column, is the date/time of the

14:21 12 examination?

14:21 13 A. Correct. That's correct.

14:21 14 Q. Then the middle column is the

14:21 15 Subjective/Objective Assessment column?

14:21 16 A. Correct.

14:21 17 Q. It's my understanding from reading the

14:21 18 regulations that they first allow the inmates to

14:21 19 describe their subjective symptoms; is that

14:21 20 correct?

14:21 21 A. Yes.

14:21 22 Q. And then they would do an objective

14:21 23 assessment of those symptoms; is that accurate?

14:21 24 A. Of their complaint, yes.

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14:21 1 Q. And then there's an assessment after

14:22 2 that; is that correct?

14:22 3 A. Correct.

14:22 4 Q. And in the last column for page 2 of

14:22 5 Exhibit No. 6 is plans, and so I'm guessing that is

14:22 6 like the follow-up based on the complaint; is that

14:22 7 correct?

14:22 8 A. Yes. It's the plan. It's what course

14:22 9 of action is to be done.

14:22 10 Q. Okay. So we are looking at this

14:22 11 particular exhibit, Exhibit 6, the date and time is

14:22 12 August -- that is either a 4 or a 9, 2012?

14:22 13 A. Yes. It looks to me, yes.

14:22 14 Q. And there is a -- looking at the third

14:22 15 line, starting in -- we'll start with the first

14:23 16 one. S/O is that symptoms of?

14:23 17 A. No, subjective and objective.

14:23 18 Q. Oh, subjective. Okay. Then what about

14:23 19 the I/H in the second line?

14:23 20 A. It would be I/M, and it's an

14:23 21 abbreviation for inmate.

14:23 22 Q. For inmate. Okay. Then there's --

14:23 23 A. I'm sorry. That is I/H, and that is

14:23 24 probably in-house. It looked like an M to me, but

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14:23 1 as I look at it closer, I think that is H and that

14:23 2 would reasonably be in-house.

14:23 3 Q. Then there's an MD/SC next to that?

14:23 4 A. Right. That would be an abbreviation

14:23 5 for MD sick call.

14:23 6 Q. Okay. And it says, For care of pain

14:23 7 and -- I'm not sure what that next word is --

14:24 8 numbness?

14:24 9 A. Right. C/O is complaint of.

14:24 10 Q. Complaint of.

14:24 11 A. And it is numbness, pain and numbness.

14:24 12 Q. Then the B/L on the next line, what does

14:24 13 that stand for?

14:24 14 A. Want to guess? You are doing pretty

14:24 15 well so far.

14:24 16 Q. It's probably faster if you do it

14:24 17 though.

14:24 18 A. Bilateral.

14:24 19 Q. Bilateral hands and feet?

14:24 20 A. Correct.

14:24 21 Q. And then SR is?

14:24 22 A. Self-reported.

14:24 23 Q. Is that joints?

14:24 24 A. Joints or joint. It might be joint, and

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14:24 1 the next word is pain causing these symptoms.

14:24 2 Q. It says, And he is unable to do daily

14:24 3 activities, is the next line?

14:24 4 A. Yes. That is what it appears, yes.

14:24 5 Q. Then there is an A that is circled. Do

14:24 6 you see that on the next line?

14:24 7 A. Yes.

14:24 8 Q. What does that stand for?

14:24 9 A. A stands for assessment.

14:25 10 Q. So assessment, bilateral hands, feet

14:25 11 pain and numbness?

14:25 12 A. Yes.

14:25 13 Q. Okay. Now, are these the types of

14:25 14 complaints that you would expect to hear from

14:25 15 somebody with rheumatoid arthritis?

14:25 16 A. Possibly, yes. These -- this statement

14:25 17 paragraph here, These would not be inconsistent

14:25 18 with the patient that had rheumatoid arthritis.

14:25 19 Q. Okay.

14:25 20 MR. LOMBARDO: I just want to jump in really

14:25 21 quick. I should have made an objection earlier.

14:25 22 Dr. Funk is doing -- based on foundation, just

14:25 23 because this is not his document. He did not

14:25 24 actually draft this. I think he's doing a good job

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14:25 1 reading the handwriting, but I just want to make  
 14:26 2 that objection to this document. Sorry for  
 14:26 3 interrupting.  
 14:26 4 BY MS. REED:  
 14:26 5 Q. Okay. Going down to sort of the bottom  
 14:26 6 of the last, like, five or so lines of Exhibit  
 14:26 7 No. 6, page 2, it appears like they are getting  
 14:26 8 complaints of joint pain off and on, stomach ache.  
 14:26 9 I'm not going to try to read that. And it says  
 14:26 10 that he's seeing blood off and on on tissue.  
 14:26 11 A. It says, Like when, is what it says.  
 14:27 12 Stomach ache like when I had H. pylori.  
 14:27 13 Q. Okay. Reading the description in the  
 14:27 14 last six lines of page 2 of Exhibit 6, does that  
 14:27 15 description -- is it consistent with what you would  
 14:27 16 expect to see from a patient with rheumatoid  
 14:27 17 arthritis?  
 14:27 18 A. No.  
 14:27 19 Q. Okay. And what is not consistent about  
 14:27 20 these six lines?  
 14:27 21 A. Because the patient is presenting with  
 14:27 22 symptoms that -- for instance, stomach ache would  
 14:27 23 not be suggestive of rheumatoid arthritis or  
 14:27 24 expected to be present in rheumatoid arthritis.

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14:27 1 Blood in the tissue would also not be present --  
 14:27 2 expected. Itchy sensation on urination also would  
 14:28 3 not be linked in or a symptom of rheumatoid  
 14:28 4 arthritis, so the presentation is not consistent at  
 14:28 5 all with rheumatoid arthritis.  
 14:28 6 Q. What about the off-and-on joint pain  
 14:28 7 that is referenced, is that consistent?  
 14:28 8 A. No.  
 14:28 9 Q. And why not?  
 14:28 10 A. Not in the description like that because  
 14:28 11 it is -- it is a progressive usually daily pain  
 14:28 12 that they have, and they would not describe it as  
 14:28 13 that and limit the symptom as being joint pain.  
 14:28 14 They would be more descriptive and relay the other  
 14:28 15 symptoms that characterize rheumatoid arthritis.  
 14:28 16 Q. If a patient who had rheumatoid  
 14:28 17 arthritis was on painkillers, for example, but  
 14:28 18 inconsistent painkillers, would their pain be off  
 14:28 19 and on?  
 14:29 20 A. The painkillers reduce the pain, but  
 14:29 21 they don't eradicate the pain. They don't relieve  
 14:29 22 it entirely. So patients who are on pain  
 14:29 23 medication that have rheumatoid arthritis will  
 14:29 24 still have pain and will relay that as a symptom,

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14:29 1 but they will have lesser pain.  
 14:29 2 Q. Okay. So there's a reference to  
 14:29 3 nordazepam?  
 14:29 4 A. Naprosyn.  
 14:29 5 Q. Naprosyn. What is that.  
 14:30 6 A. Naprosyn is a nonsteroidal  
 14:30 7 antiinflammatory medication.  
 14:30 8 Q. And is that a medication that you would  
 14:30 9 use to treat someone with rheumatoid arthritis?  
 14:30 10 A. It could be. Yes, it could be used in  
 14:30 11 rheumatoid arthritis.  
 14:30 12 Q. And what -- why would a doctor use that  
 14:30 13 to treat rheumatoid arthritis?  
 14:30 14 A. It would help to alleviate -- it's a  
 14:30 15 nonspecific medication that is used for many  
 14:30 16 different types of pain. It's not specific to  
 14:30 17 rheumatoid arthritis, but it reduces pain and  
 14:30 18 inflammation.  
 14:30 19 Q. And is that a prescription medication  
 14:30 20 for the facility, or is that available at the  
 14:30 21 commissary?  
 14:30 22 A. Each facility has its own commissary --  
 14:30 23 list of commissary items. What is on the  
 14:30 24 commissary is determined by the warden. They

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14:30 1 sometimes have nonsteroidals, and I think in the  
 14:31 2 deposition, it was stated -- Mr. Daniels stated  
 14:31 3 that Motrin was available. But naprosyn in a lower  
 14:31 4 dose is over-the-counter. It's called Aleve, and  
 14:31 5 it's possible, but I don't know if it's available  
 14:31 6 from the commissary.  
 14:31 7 Q. Okay. If someone was -- I'm going to  
 14:31 8 stop sharing this now. If someone was prescribed  
 14:31 9 that medication and it, you know, was sold out at  
 14:31 10 the commissary but generally available, would they  
 14:31 11 be able to get it from the physician at the  
 14:31 12 facility instead?  
 14:31 13 A. Yes.  
 14:31 14 Q. And what would they have to do -- what  
 14:31 15 would an inmate have to do to get that medication  
 14:31 16 from the physician?  
 14:31 17 A. The inmate would have to request, and  
 14:31 18 the physician would have to agree and write the  
 14:31 19 prescription for it.  
 14:31 20 Q. When physicians draft these progress  
 14:32 21 notes, do they allow the patients to review them  
 14:32 22 before finalizing?  
 14:32 23 A. At the time, you mean, do they allow  
 14:32 24 them to --



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14:32 1 Q. Yes.

14:32 2 A. No. No, they don't. They have access

14:32 3 to the notes and can review them, but it isn't

14:32 4 reviewed with them. They generally are -- the

14:32 5 notes are generally in view of the patient, as the

14:32 6 writing of it is typically done in -- with the

14:32 7 patient present and they can see what you are

14:32 8 writing. So they commonly do, in fact, see it, but

14:32 9 there's no policy that says, you know, you have

14:33 10 to -- you need to prove my note before I submit it

14:33 11 or whatever.

14:33 12 Q. Okay. Are you familiar with the term

14:33 13 "discovery responses"?

14:33 14 A. The legal term?

14:33 15 Q. Yes.

14:33 16 A. Somewhat.

14:33 17 Q. For this case were you asked to help

14:33 18 with any discovery responses?

14:33 19 A. I may have been in one of the

14:33 20 conversations. I don't recall, but I am involved

14:33 21 in many cases. It's hard for me to keep them all

14:33 22 straight. I may have been, but I don't recall.

14:33 23 Q. Okay. If a prescription is not on the

14:34 24 approved medication list or if a particular

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14:34 1 medication is not on the approved medication list,

14:34 2 does the inmate still have access to it?

14:34 3 A. Yes.

14:34 4 Q. How so?

14:34 5 A. By the physician ordering it and filling

14:34 6 out a non-formulary request.

14:34 7 Q. Can an inmate request a medication that

14:34 8 is not on the approved medication list?

14:34 9 A. They can request it, yes. They can't

14:34 10 order it, but they can certainly request it of a

14:34 11 physician.

14:34 12 Q. Okay. If a physician recommends a

14:35 13 follow-up appointment and an inmate is not able to

14:35 14 attend for some reason, is there a protocol for

14:35 15 making sure that the inmate is, in fact, seen for a

14:35 16 follow-up, even if it's not on the scheduled date?

14:35 17 A. It depends on the reason why the

14:35 18 appointment is not kept. Patients have a right to

14:35 19 refuse. If they refuse, then they have refused the

14:35 20 visit. They would not be rescheduled.

14:35 21 If they are not seen for an

14:35 22 administrative purpose -- for instance, there's a

14:35 23 lockdown or something like that, where they are not

14:35 24 able to come because of security reasons or there's

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14:35 1 some -- a fight or something occurring, then they

14:35 2 would be rescheduled. They should be rescheduled.

14:35 3 Q. Okay.

14:36 4 MS. REED: Can I just have a five-minute break

14:36 5 to review my notes?

14:36 6 MR. LOMBARDO: Sure.

14:36 7 (WHEREUPON, a recess was had.)

14:44 8 MS. REED: We are now back on the record.

14:44 9 BY MS. REED:

14:44 10 Q. Dr. Funk, do you understand that you are

14:44 11 still under oath?

14:44 12 A. Yes, I do.

14:44 13 Q. Okay. Have you reviewed the assessment

14:44 14 done by Dr. Amar Sawar?

14:44 15 A. Yes.

14:44 16 Q. And when you reviewed his assessment,

14:44 17 was there anything in particular that stood out to

14:44 18 you that you disagreed with?

14:44 19 A. Not that I disagreed with. I saw some

14:45 20 inconsistency, I thought, in his -- in his report.

14:45 21 Q. What was the inconsistency?

14:45 22 A. The examination of his joint. In the

14:45 23 first encounter he wrote that he had normal joints

14:45 24 and normal strength. Then when you saw him six

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14:45 1 weeks later, stated he had plus one swelling, I

14:45 2 think is what he wrote.

14:45 3 It would be unusual for a person to have

14:45 4 developed that in six weeks, where it had not been

14:45 5 present the first time. That just seemed -- that

14:45 6 struck me as just being a little unusual.

14:46 7 Q. Now, in Dr. Sawar's assessment, he notes

14:46 8 seropositive rheumatoid arthritis, generalized

14:46 9 osteoarthritis, and peripheral neuropathy. Do you

14:46 10 recall that assessment?

14:46 11 A. Neuropathy. That was in one of his

14:46 12 visits. That is not his initial impression. When

14:46 13 he first saw the patient, his impression was

14:46 14 different. I don't have the note in front of me,

14:46 15 but he did not assess him to have rheumatoid

14:46 16 arthritis on the first visit.

14:46 17 Q. So I think the particular date I'm

14:46 18 looking at is June 17, 2016, so it's one of the

14:46 19 later visits.

14:46 20 A. Yes.

14:46 21 Q. So do you disagree with that assessment

14:47 22 then?

14:47 23 A. Yes, I disagree with -- yes, I do

14:47 24 disagree with it.

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14:47 1 Q. Okay.

14:47 2 A. Not his -- not all aspects of it. I

14:47 3 do -- I agree with him having osteoarthritis and

14:47 4 possibly peripheral neuropathy, although his EMG

14:47 5 was normal, but it's possible to have peripheral

14:47 6 neuropathy with a normal EMG.

14:47 7 But the diagnosis of rheumatoid

14:47 8 arthritis is questionable. My opinion is that he

14:47 9 does not meet criteria for that. I have not

14:47 10 personally examined him, so I can't speak from my

14:47 11 personal view. But from review of all of the

14:47 12 information -- and, again, I have a perspective

14:47 13 that Dr. Sawar does not, that having been able to

14:48 14 know what the consequence was of treatment and his

14:48 15 subsequent exams by physicians, what that has

14:48 16 revealed.

14:48 17 Plus, I'm certain that he did not review

14:48 18 every encounter since he was incarcerated, as I

14:48 19 did. I respect him as a rheumatologist, and I'm

14:48 20 not detracting from him, but I think if he had

14:48 21 access to the same material that I did, his opinion

14:48 22 would also change.

14:48 23 Q. Is there a benefit to actually

14:48 24 conducting a physical exam versus just reviewing

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14:48 1 medical records?

14:48 2 A. Yes.

14:48 3 Q. And for rheumatoid arthritis in

14:48 4 particular, is it easier to make an objective

14:48 5 assessment of the patient's symptoms if you are

14:48 6 assessing him in person?

14:48 7 A. Yes, of course.

14:48 8 Q. Is there another rheumatologist that you

14:49 9 would have referred the plaintiff to besides

14:49 10 Dr. Sawar?

14:49 11 A. There are many rheumatologists. I don't

14:49 12 know him personally, so, again, I don't think it's

14:49 13 the difference of a person. It's the perspective

14:49 14 that is gained from having all of the information

14:49 15 that exists available in making an assessment. And

14:49 16 when anyone does that and when they have limited

14:49 17 information, then their judgment can only be -- is

14:49 18 confined by that.

14:49 19 Q. So let me ask a different question. If

14:49 20 you didn't have the benefit of all of the

14:50 21 information that you have now, if you were in

14:50 22 Dr. Sawar's shoes doing an assessment, would you

14:50 23 have agreed with his assessment without -- taking

14:50 24 out the extra knowledge that you have?

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14:50 1 A. I may have. I mean, only seeing the

14:50 2 patient for those brief periods of time and not

14:50 3 being able to review records, I may have because

14:50 4 these things that he said at the time may have led

14:50 5 him -- I may have come to the same conclusion.

14:50 6 Q. Do you disagree with the prescription of

14:50 7 methotrexate for that assessment?

14:50 8 A. Yes. I do now, yes.

14:50 9 Q. Would you -- if you credit Dr. Sawar and

14:51 10 agree with his assessment, then would you agree

14:51 11 with the prescription for methotrexate?

14:51 12 A. So in the situation that I did not have

14:51 13 access to his other records and subsequent records,

14:51 14 I think it would have been more reasonable to have

14:51 15 observed him over a period of time, reexamined him

14:51 16 because methotrexate is a -- it's a toxic drug. It

14:51 17 functions -- the only way that one has benefit is

14:51 18 by your immune system being depressed, and that is

14:51 19 a very serious condition. You could potentially

14:51 20 die from that, if you were to develop pneumonia,

14:51 21 for example, or some other infection. So I think

14:51 22 it would have been more reasonable to have held off

14:51 23 and examined him again before making that decision.

14:52 24 Q. So when an outside referral is made, do

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14:52 1 the physicians provide the outside physician with

14:52 2 the medical records that were the basis of that

14:52 3 referral?

14:52 4 A. They provide limited records. It would

14:52 5 be the -- his records were probably more than 1,000

14:52 6 pages, and they are in paper. It would be

14:52 7 impractical to do that, so we don't provide all of

14:52 8 the records. In practice, it's not that it's not

14:52 9 valuable. It is. But in practice, people rely on

14:52 10 a patient's history in relaying their symptoms, and

14:52 11 they don't take the time to review the records.

14:52 12 It would be -- it took me probably four

14:53 13 hours to go through records, and you know from

14:53 14 patients, when you have seen the doctor, they don't

14:53 15 spend four hours with you.

14:53 16 Q. Just to clarify. You don't know whether

14:53 17 or not Dr. Sawar read the prior medical records or

14:53 18 which medical records he received, it's just in

14:53 19 general practice, your assumption is it's likely he

14:53 20 did not review them?

14:53 21 A. No. If they had copied the thousand

14:53 22 pages, I would have heard about it. It would be

14:53 23 unusual. It would not be consistent with practice

14:53 24 to do that. It never occurs to provide the entire

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14:53 1 record, make a copy of it and send it. So I don't  
 14:53 2 know -- I was not specifically involved, but that  
 14:53 3 would be an unusual and unprecedented occurrence  
 14:53 4 from my 26 years of working in corrections.  
 14:53 5 Q. Let me ask, but what about with limited  
 14:54 6 records that would be related to this particular  
 14:54 7 referral, would it be typical for him to receive  
 14:54 8 those?  
 14:54 9 A. Yes. To provide some information, like  
 14:54 10 laboratory results, that likely was provided so  
 14:54 11 that they would not necessarily need to be  
 14:54 12 repeated, X-ray results. That is the reason why  
 14:54 13 those kind of things were -- would be provided, but  
 14:54 14 all of the records are relevant. And even where  
 14:54 15 there are complaints not related to rheumatologic  
 14:54 16 conditions are relevant records in this setting.  
 14:54 17 It tells me what was bothering a patient, what  
 14:54 18 level he chose to come forward with complaints,  
 14:54 19 whether he had significant complaints or minor  
 14:54 20 complaints. Some people just complain a lot. We  
 14:54 21 have those kind of patients, and that is reflected  
 14:54 22 in their medical record. So all of it is important  
 14:54 23 and it should be reviewed.  
 14:54 24 Q. Okay. And in your time as the regional

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14:57 1 family history.  
 14:57 2 Q. And there's also a reference to  
 14:57 3 complaints of whole body joint aches over the past  
 14:57 4 several years?  
 14:57 5 A. Yes. Increasing over the past several  
 14:57 6 years, is what it states.  
 14:57 7 Q. Okay. And it says, Some days he's  
 14:57 8 confined to his bed. Do you see that?  
 14:57 9 A. Yes.  
 14:57 10 Q. In your experience, are those complaints  
 14:57 11 consistent with someone who has rheumatoid  
 14:57 12 arthritis?  
 14:57 13 A. No. It would be more consistent with  
 14:57 14 other conditions.  
 14:57 15 Q. What other conditions?  
 14:57 16 A. Other rheumatologic conditions, but not  
 14:57 17 typically of a patient with rheumatoid arthritis.  
 14:57 18 So things like fibromyalgia would be one syndrome.  
 14:58 19 Polymyalgia rheumatica, polymyositis, lupus. Those  
 14:58 20 diseases would be more consistent with a whole body  
 14:58 21 kind of a complaint.  
 14:58 22 Q. And if someone has a whole body  
 14:58 23 complaint and a family history of rheumatoid  
 14:58 24 arthritis, would it be appropriate to refer them to

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14:55 1 medical director, what percentage of your  
 14:55 2 supervisory duties have involved diagnosis of  
 14:55 3 rheumatoid arthritis?  
 14:55 4 A. A very small percent, only from patients  
 14:55 5 that I would directly see, and that represents a  
 14:55 6 very small percent.  
 14:55 7 Q. Okay. One quick document and then I  
 14:55 8 will pass it over to opposing counsel. Can you see  
 14:55 9 my screen, Dr. Funk?  
 14:55 10 A. Yes.  
 14:55 11 Q. I have what is marked as Exhibit No. 7.  
 14:56 12 Exhibit No. 7 is another progress note. The date  
 14:56 13 on the top of the progress note is October 26,  
 14:56 14 2010, and it's referenced as a PA note. Do you see  
 14:56 15 that?  
 14:56 16 A. Yes.  
 14:56 17 Q. I'll give you a chance to review this  
 14:56 18 quickly and then I'll ask a few questions.  
 14:56 19 A. Okay.  
 14:56 20 Q. Now, this seems to indicate that there  
 14:57 21 was a family history of rheumatoid arthritis. Is  
 14:57 22 that how you read this progress note as well?  
 14:57 23 A. Yes. The patient reported to the  
 14:57 24 physician assistant that there was a maternal

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14:58 1 a rheumatologist for further study?  
 14:58 2 A. No, I would not say so.  
 14:58 3 Q. Why not?  
 14:58 4 A. It would -- because that -- evaluation  
 14:58 5 is appropriately done by primary care providers to  
 14:58 6 determine what the disorder is, if there is a  
 14:59 7 disorder.  
 14:59 8 Q. And when does it become appropriate to  
 14:59 9 refer it out to a rheumatologist?  
 14:59 10 A. When the clinician feels they need an  
 14:59 11 opinion for different reasons in the management of  
 14:59 12 the patient by somebody that is -- has a  
 14:59 13 specialty -- as a specialist, as a rheumatologist.  
 14:59 14 MS. REED: That is all of my -- sorry. A  
 14:59 15 couple of housekeeping matters. So throughout the  
 14:59 16 deposition, Dr. Funk, we have talked about various  
 14:59 17 documents related to your job duties, related to  
 15:00 18 the physicians, and I believe those documents are  
 15:00 19 responsive to both the deposition notice, which  
 15:00 20 asks for documents, and to prior discovery. And so  
 15:00 21 I'm just making a note on the record for opposing  
 15:00 22 counsel that we will be following up on that and  
 15:00 23 pursuing those documents. It's not a question for  
 15:00 24 you, Dr. Funk. It's just a note for the record.

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15:00 1 MR. LOMBARDO: I'll just respond briefly. As  
 15:00 2 stated in the e-mail, Rule 30 specifically states  
 15:00 3 that document requests being made to a party in  
 15:00 4 connection with the deposition notice must be  
 15:00 5 accompanied by a Rule 34 request.

15:00 6 In this particular case, fact discovery  
 15:00 7 has been closed for more than a year. Judge  
 15:00 8 Cummings made an order allowing discovery to be  
 15:00 9 reopened for the limited purpose of conducting  
 15:00 10 today's 30(b)(6) deposition.

15:00 11 Defendants take the position that no  
 15:00 12 further -- the document requests that were made  
 15:01 13 part of the 30(b)(6) notice, that there's no  
 15:01 14 obligation for us to respond to those.

15:01 15 MS. REED: We'll just note for the record that  
 15:01 16 to the extent that there are documents that were  
 15:01 17 reviewed specifically for this deposition and  
 15:01 18 relied upon as well as documents that were not  
 15:01 19 responsive, like I said, we'll be following up on  
 15:01 20 that.

15:01 21 To that end, I'm going to leave the  
 15:01 22 deposition open so that we can resolve any  
 15:01 23 discovery dispute, and that concludes my  
 15:01 24 questioning. I'll turn it over to opposing

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15:01 1 counsel.

15:01 2 MR. LOMBARDO: Sure. Just briefly. All  
 15:01 3 documents that Dr. Funk has been provided and  
 15:01 4 reviewed in connection with this deposition have  
 15:01 5 been produced already, and we would object to  
 15:01 6 leaving this deposition open or a second part of  
 15:01 7 this deposition.

15:01 8 EXAMINATION

15:01 9 BY MR. LOMBARDO:

15:01 10 Q. I'll start with just some brief  
 15:01 11 follow-up questions.

15:01 12 Dr. Funk, you stated earlier that  
 15:02 13 each IDOC correctional facility has specific  
 15:02 14 guidelines for specific needs. Were you referring  
 15:02 15 to a written set of guidelines that is facility  
 15:02 16 specific?

15:02 17 A. There are both written and verbal, yes.

15:02 18 Q. Were the written ones you are referring  
 15:02 19 to Wexford documents, or are you referring to  
 15:02 20 institutional directives that are generated by the  
 15:02 21 Illinois Department of Corrections?

15:02 22 A. I was referring to those guidelines  
 15:02 23 including institutional directives but,  
 15:02 24 specifically, those that are formulated by the site

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15:02 1 or the Office of Health Services specific to the  
 15:02 2 site.

15:02 3 Q. Are these Wexford documents or State  
 15:02 4 documents?

15:02 5 A. No. Sorry. They are all State. I was  
 15:02 6 referring to State documents.

15:02 7 Q. You also inferred that each employee has  
 15:03 8 an employee agreement with Wexford. So in law, a  
 15:03 9 contract employee has kind of a certain legal  
 15:03 10 definition.

15:03 11 Were you saying that Wexford employees  
 15:03 12 are contract employees, or could you clarify what  
 15:03 13 agreements that you are referring to?

15:03 14 A. Okay. So I'm not sure exactly what the  
 15:03 15 definition of contract employee is, but it is  
 15:03 16 actually an offer letter. I take that as a  
 15:03 17 contract or an agreement, so there's an agreement  
 15:03 18 of employment. But I don't even know what the  
 15:03 19 definition of a contract employee would be.

15:03 20 Q. Okay. So you are referring to an offer  
 15:03 21 letter that is signed by the employee who accepts  
 15:03 22 the position, when you are referring to a contract  
 15:03 23 employee?

15:03 24 A. Yes. I was inferring that to be a

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15:03 1 contract. I see that, in my opinion, to be a  
 15:03 2 contract.

15:03 3 Q. The one that I was referring to before  
 15:03 4 is kind of like a professional athlete who will  
 15:04 5 sign a contract where they get X amount of dollars  
 15:04 6 for X amount of years. That can happen outside as  
 15:04 7 a professional service too, so that is a legal  
 15:04 8 definition of a contract employee.

15:04 9 A. Okay.

15:04 10 Q. That is not what you were referring to,  
 15:04 11 correct?

15:04 12 A. No.

15:04 13 Q. You referred a couple times to the  
 15:04 14 position of the health care unit administrator. Is  
 15:04 15 that a Wexford employee or an IDOC employee?

15:04 16 A. IDOC employee.

15:04 17 Q. You also referenced a continuous quality  
 15:04 18 improvement meeting. Is that a meeting that is  
 15:04 19 only attended by Wexford employees, or is that a  
 15:04 20 joint function of both Wexford and State personnel?

15:04 21 A. The second, both by Wexford and State.

15:04 22 Q. Is it the health care unit administrator  
 15:05 23 that runs that meeting?

15:05 24 A. Yes, or the person that she or he

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15:05 1 designates.  
 15:05 2 Q. We talked a little bit about medication,  
 15:05 3 specifically over-the-counter medications. I think  
 15:05 4 you mentioned Aleve. Motrin was another one that  
 15:05 5 was mentioned.

15:05 6 If a medicine is over-the-counter, can  
 15:05 7 an inmate still get it for free if the provider  
 15:05 8 deems it is clinically indicated and orders it for  
 15:05 9 them?

15:05 10 A. Yes. So there are two things. One is  
 15:05 11 that the prescription -- the medication at a higher  
 15:05 12 level has to be provided by a prescription, but the  
 15:05 13 provider can order it and it would be less costly  
 15:05 14 for a provider to order it rather than the patient  
 15:05 15 obtaining it from the commissary.

15:05 16 Q. Is rheumatoid arthritis a condition that  
 15:05 17 can be cured?

15:06 18 A. No. It would not be -- it would not be  
 15:06 19 cured, no.

15:06 20 Q. When you were discussing treatments  
 15:06 21 earlier, those treatments were -- excuse me -- are  
 15:06 22 intended to address the symptoms of rheumatoid  
 15:06 23 arthritis, not to eradicate the disease itself; is  
 15:06 24 that accurate?

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15:06 1 A. Not quite. It is to address the  
 15:06 2 symptoms. But it is also to alter the course of  
 15:06 3 the illness, and that is the effects of the --  
 15:06 4 primarily on the effects of the joint but also on  
 15:06 5 other organs where that -- when a patient has  
 15:06 6 active disease.

15:06 7 Q. Based on your review of Mr. Daniels'  
 15:06 8 medical records, did his complaints regarding joint  
 15:06 9 pain ever require emergent medical care?

15:06 10 A. No.

15:06 11 Q. How about urgent medical care?

15:07 12 A. Neither. No.

15:07 13 Q. What about his complaints related to  
 15:07 14 stomach pain, did those ever require urgent medical  
 15:07 15 care?

15:07 16 A. No.

15:07 17 MS. REED: Objection, lacks foundation, vague.

15:07 18 BY THE WITNESS:

15:07 19 A. No.

15:07 20 BY MR. LOMBARDO:

15:07 21 Q. What about emergent medical care?

15:07 22 A. No.

15:07 23 MS. REED: Same objection.  
 24

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15:07 1 BY MR. LOMBARDO:

15:07 2 Q. And, Dr. Funk, you did spend time, as  
 15:07 3 you stated, reading these hundreds of pages of  
 15:07 4 Mr. Daniels' medical records in his IDOC medical  
 15:07 5 file?

15:07 6 A. Yes.

15:07 7 Q. Based on your review, do you feel that  
 15:07 8 you are in a position to give an opinion whether he  
 15:07 9 had an emergent or urgent medical condition?

15:07 10 A. Yes, I am.

15:07 11 MS. REED: Objection, lacks foundation.

15:07 12 BY MR. LOMBARDO:

15:07 13 Q. Dr. Funk, you gave several opinions  
 15:07 14 today that are beyond the scope of a layperson.  
 15:07 15 Were all of those opinions made to a degree of  
 15:07 16 medical certainty?

15:07 17 A. Yes, I would say so.

15:08 18 Q. Was there anything else that you wanted  
 15:08 19 to comment on or clarify any of your answers?

15:08 20 A. Well, my comment of what I would have is  
 15:08 21 his evaluation subsequent to his release into the  
 15:08 22 comment also demonstrated an inconsistent picture  
 15:08 23 with him having rheumatoid arthritis. The findings  
 15:08 24 of those four visits that occurred, again,

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15:08 1 strengthened and informed my belief that he did not  
 15:09 2 have rheumatoid arthritis, and his symptoms were  
 15:09 3 due to other factors and that was their opinion as  
 15:09 4 well.

15:09 5 MR. LOMBARDO: All right. I have no more  
 15:09 6 questions based on that.

15:09 7 MS. REED: I don't have any other questions.

15:09 8 MR. LOMBARDO: Okay. Dr. Funk, would you like  
 15:09 9 to reserve signature or waive?

15:09 10 THE WITNESS: I'll waive it.

15:09 11 MR. LOMBARDO: Excellent. Did you order the  
 15:10 12 transcript?

15:10 13 MS. REED: I would like a copy of the  
 15:10 14 transcript.

15:10 15 MR. LOMBARDO: We'll also take a copy, e-trans  
 15:10 16 only, please.

17 FURTHER DEPONENT SAITH NOT.

18 (WHEREUPON, certain documents

19 were marked Funk Deposition

20 Exhibit Nos. 1 through 7, for

21 identification.)  
 22  
 23  
 24

1 STATE OF ILLINOIS )  
2 ) SS:  
3 COUNTY OF C O O K )

4 I, KRISTIN C. BRAJKOVICH, a Certified  
5 Shorthand Reporter of said state, do hereby  
6 certify:

7 That previous to the commencement of the  
8 examination of the witness, the witness was duly  
9 sworn to testify the whole truth concerning the  
10 matters herein;

11 That the foregoing deposition transcript  
12 was reported stenographically by me,  
13 was thereafter reduced to typewriting under my  
14 personal direction and constitutes a true record  
15 of the testimony given and the proceedings had;

16 That the said deposition was taken  
17 before me at the time and place specified;

18 That I am not a relative or employee  
19 or attorney or counsel, nor a relative or  
20 employee of such attorney or counsel for any of  
21 the parties hereto, nor interested directly or  
22 indirectly in the outcome of this action.

23 IN WITNESS WHEREOF, I do hereunto set my  
24 hand and affix my seal of office at Chicago,  
Illinois, this 28th day of March 2022.

\_\_\_\_\_  
C.S.R. Certificate No. 84-3810.